



## Senate

General Assembly

**File No. 313**

January Session, 2017

Substitute Senate Bill No. 946

*Senate, March 30, 2017*

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS'  
RECOMMENDATIONS FOR TECHNICAL AND OTHER CHANGES TO  
THE INSURANCE AND RELATED STATUTES.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (e) of section 5-259 of the general statutes is  
2 repealed and the following is substituted in lieu thereof (*Effective*  
3 *October 1, 2017*):

4 (e) Notwithstanding the provisions of subsection (a) of this section,  
5 vending stand operators eligible for membership in the state  
6 [employees'] employees retirement system pursuant to section 5-175a  
7 shall be eligible for coverage under the group hospitalization and  
8 medical and surgical insurance plans procured under this section,  
9 provided the cost for such operators' insurance coverage shall be paid  
10 by the Department of Rehabilitation Services from vending machine  
11 income pursuant to section 10-303.

12 Sec. 2. Subsection (c) of section 12-211 of the general statutes is  
13 repealed and the following is substituted in lieu thereof (*Effective*  
14 *October 1, 2017*):

15 (c) The provisions of this section shall not apply to ad valorem taxes  
16 on real or personal property, personal income taxes, fees for agents'  
17 licenses, special purpose assessments imposed in connection with  
18 particular kinds of insurance including, but not limited to, workers'  
19 compensation assessments and Insurance Guaranty Association Fund  
20 assessments, or to premium taxes on special health care plans as  
21 defined in [sections] section 38a-564 of the general statutes, revision of  
22 1958, revised to January 1, 2013, and section 38a-551, except in the case  
23 where another state or foreign country imposes upon Connecticut  
24 domiciled insurers retaliatory charges for such taxes, fees or  
25 assessments.

26 Sec. 3. Section 19a-904b of the general statutes is repealed and the  
27 following is substituted in lieu thereof (*Effective October 1, 2017*):

28 (a) Not later than thirty days after the date that a health care  
29 provider stops accepting patients who are enrolled in an insurance  
30 plan, such health care provider shall notify, in writing, the applicable  
31 health carrier.

32 (b) Each health carrier shall update [, not less than monthly,] its  
33 health care provider directory or directories in accordance with the  
34 provisions of section 38a-477h.

35 Sec. 4. Section 38a-14 of the general statutes is repealed and the  
36 following is substituted in lieu thereof (*Effective October 1, 2017*):

37 (a) [The commissioner shall, as often as the commissioner deems it  
38 expedient, examine into the affairs of] For the purposes of this section,  
39 "company" means any insurance company or health care center doing  
40 business in this state, any corporation or association collecting data  
41 utilized by any such insurance company in the underwriting of  
42 insurance policies and any corporation organized under any law of

43 this state or having an office in this state, which corporation is engaged  
44 in, or claiming or advertising that it is engaged in, organizing or  
45 receiving subscriptions for or disposing of stock of, or in any manner  
46 aiding or taking part in the formation or business of, an insurance  
47 company or companies, or that is holding the capital stock of one or  
48 more insurance corporations for the purpose of controlling the  
49 management thereof, as voting trustees or otherwise.

50 (b) The commissioner shall, as often as the commissioner deems it  
51 expedient, examine into the affairs of any company. In scheduling and  
52 determining the nature, scope and frequency of the examinations, the  
53 commissioner shall consider such matters as the results of financial  
54 statement analyses and ratios, changes in management or ownership,  
55 actuarial opinions, reports of independent certified public accountants  
56 and such other criteria as set forth in the examiners' handbook adopted  
57 by the National Association of Insurance Commissioners and in effect  
58 at the time the commissioner exercises discretion under this section.

59 (c) (1) To carry out examinations under this section, the  
60 commissioner may appoint one or more competent persons as  
61 examiners, who shall not be officers of, connected with or interested in  
62 any [insurance] company, other than as policyholders. The  
63 commissioner may engage the services of attorneys, appraisers,  
64 independent actuaries, independent certified public accountants or  
65 other professionals and specialists as examiners to assist the  
66 commissioner in conducting the examinations under this section, the  
67 cost of which shall be borne by the company that is the subject of the  
68 examination.

69 (2) In conducting the examination, the commissioner, the  
70 commissioner's actuary or any examiner authorized by the  
71 commissioner may examine, under oath, the officers and agents of  
72 such a company, [health care center, corporation or association] and all  
73 persons deemed to have material information regarding the company's  
74 [, health care center's, corporation's or association's] property or  
75 business. Each such company [, health care center, corporation or

76 association,] or its officers and agents [,] shall produce the books and  
77 papers in its or their possession, relating to its business or affairs, and  
78 any other person may be required to produce any book or paper in  
79 such person's custody that is deemed to be relevant to such  
80 examination, for inspection by the commissioner, the commissioner's  
81 actuary or examiners. The officers and agents of the company [, health  
82 care center, corporation or association] shall facilitate the examination  
83 and aid the examiners in making the same so far as it is in their power  
84 to do so. The refusal of any company, by its officers, directors,  
85 employees or agents, to submit to examination or to comply with any  
86 reasonable written request of the examiners shall be grounds for  
87 suspension of, refusal of or nonrenewal of any license or authority held  
88 by the company to engage in an insurance or other business subject to  
89 the commissioner's jurisdiction. Any such proceedings for suspension,  
90 revocation or refusal of any license or authority shall be conducted  
91 pursuant to subsection (c) of section 38a-41.

92 (3) In conducting the examination, the examiner shall observe those  
93 guidelines and procedures set forth in the examiners' handbook  
94 adopted by the National Association of Insurance Commissioners. The  
95 commissioner may also adopt such other guidelines or procedures as  
96 the commissioner may deem appropriate.

97 (d) In lieu of an examination under this section of any foreign or  
98 alien insurer licensed in this state, the commissioner may accept an  
99 examination report on such insurer prepared by the insurance  
100 department for the [company's] insurer's state of domicile or port-of-  
101 entry state if (1) such state's insurance department was, at the time of  
102 the examination, accredited under the National Association of  
103 Insurance Commissioners' financial regulation standards and  
104 accreditation program, or (2) the examination is performed under the  
105 supervision of an accredited insurance department or with the  
106 participation of one or more examiners who are employed by such an  
107 accredited state insurance department and who, after a review of the  
108 examination workpapers and report, state under oath that the  
109 examination was performed in a manner consistent with the standards

110 and procedures required by their insurance department.

111 (e) (1) Nothing contained in this section shall be construed to limit  
112 the commissioner's authority to terminate or suspend any examination  
113 in order to pursue legal or regulatory action pursuant to the insurance  
114 laws of this state. Findings of fact and conclusions made pursuant to  
115 any examination shall be prima facie evidence in any legal or  
116 regulatory action.

117 (2) Nothing contained in this section shall be construed to limit the  
118 commissioner's authority in such legal or regulatory action to use and,  
119 if appropriate, to make public any final or preliminary examination  
120 report, any examiner or company workpapers or other documents, or  
121 any other information discovered or developed during the course of  
122 any examination.

123 (3) Not later than sixty days following completion of the  
124 examination, the examiner in charge shall file, under oath, with the  
125 Insurance Department a verified written report of examination. Upon  
126 receipt of the verified report, the Insurance Department shall transmit  
127 the report to the [entity] company examined, together with a notice  
128 that shall afford the [entity] company examined a reasonable  
129 opportunity, not to exceed thirty days, to make a written submission  
130 or rebuttal with respect to any matters contained in the examination  
131 report. Not later than thirty days after the period allowed for the  
132 receipt of written submissions or rebuttals, the commissioner shall  
133 fully consider and review the report, together with any written  
134 submissions or rebuttals and any relevant portions of the examiner's  
135 workpapers and enter an order: (A) Adopting the examination report  
136 as filed or with modification or corrections. If the examination report  
137 reveals that the [entity] company is operating in violation of any law,  
138 regulation or prior order of the commissioner, the commissioner may  
139 order the company to take any action the commissioner considers  
140 necessary and appropriate to cure such violation; (B) rejecting the  
141 examination report with directions to the examiners to reopen the  
142 examination for purposes of obtaining additional data, documentation

143 or information, and refiling pursuant to this subdivision; or (C) calling  
144 for an investigatory hearing with not less than twenty days' notice to  
145 the company for purposes of obtaining additional documentation,  
146 data, information and testimony.

147 (4) (A) The commissioner shall transmit the examination report  
148 adopted pursuant to subparagraph (A) of subdivision (3) of this  
149 subsection or a summary thereof to the [entity] company examined,  
150 together with any recommendations or written statements from the  
151 commissioner or the examiner. The secretary of the board of directors  
152 or similar governing body of the [entity] company shall provide a copy  
153 of the report or summary to each director and shall certify to the  
154 commissioner, in writing, that a copy of the report or summary has  
155 been provided to each director.

156 (B) Not later than one hundred twenty days after receiving the  
157 report or summary, the chief executive officer or the chief financial  
158 officer of the [entity] company examined shall present the report or  
159 summary to the [entity's] company's board of directors or similar  
160 governing body at a regular or special meeting.

161 (f) (1) All orders entered pursuant to subdivision (3) of subsection  
162 (e) of this section shall be accompanied by findings and conclusions  
163 resulting from the commissioner's consideration and review of the  
164 examination report, relevant examiner workpapers and any written  
165 submissions or rebuttals. The findings and conclusions that form the  
166 basis of any such order of the commissioner shall be subject to review  
167 as provided in section 38a-19.

168 (2) Any investigatory hearing conducted under subparagraph (C) of  
169 subdivision (3) of subsection (e) of this section by the commissioner or  
170 the commissioner's authorized representative, shall be conducted as a  
171 nonadversarial confidential investigatory proceeding as necessary for  
172 the resolution of any inconsistencies, discrepancies or disputed issues  
173 apparent (A) upon the filed examination report, (B) raised by or as a  
174 result of the commissioner's review of relevant workpapers, or (C) by  
175 the written submission or rebuttal of the company. Not later than

176 twenty days after the conclusion of any such hearing, the  
177 commissioner shall enter an order pursuant to subparagraph (A) of  
178 subdivision (3) of subsection (e) of this section. The commissioner shall  
179 not appoint an examiner as an authorized representative to conduct  
180 the hearing. The hearing shall proceed expeditiously with discovery by  
181 the [entity] company limited to the examiner's workpapers that tend to  
182 substantiate any assertions set forth in any written submission or  
183 rebuttal. The commissioner or the commissioner's authorized  
184 representative may issue subpoenas for the attendance of any  
185 witnesses or the production of any documents deemed relevant to the  
186 investigation, whether under the control of the department, the [entity]  
187 company or other persons. The documents produced shall be included  
188 in the record and testimony taken by the commissioner or the  
189 commissioner's authorized representative shall be under oath and  
190 preserved for the record. Nothing contained in this section shall  
191 require the department to disclose any information or records that  
192 would indicate or show the existence or content of any investigation or  
193 activity of a criminal justice agency. The hearing shall proceed with the  
194 commissioner or the commissioner's authorized representative posing  
195 questions to the persons subpoenaed. Thereafter, the [entity] company  
196 and the Insurance Department may present testimony relevant to the  
197 investigation. Cross-examination shall be conducted only by the  
198 commissioner or the commissioner's authorized representative. The  
199 [entity] company and the Insurance Department shall be permitted to  
200 make closing statements and may be represented by counsel of their  
201 choice.

202 (g) The commissioner may, if the commissioner deems it in the  
203 public interest, publish any such report, or the result of any such  
204 examination contained therein, in one or more newspapers of the state.

205 (h) The commissioner shall, at least once in every five years, visit  
206 and examine the affairs of each domestic [insurance company] insurer,  
207 domestic health care center, domestic fraternal benefit society, and  
208 foreign and alien [insurance company] insurer doing business in this  
209 state. Notwithstanding subdivision (1) of subsection (c) of this section,

210 no domestic [insurance company] insurer or such other domestic  
211 entity subject to examination under this section shall pay as costs  
212 associated with the examination the salaries, fringe benefits [,  
213 traveling] or travel and maintenance expenses of examining personnel  
214 of the Insurance Department engaged in such examination if such  
215 domestic [company] insurer or domestic entity is otherwise liable to  
216 assessment levied under section 38a-47, except that a domestic  
217 [insurance company] insurer or such other domestic entity shall pay  
218 the [traveling] travel and maintenance expenses of examining  
219 personnel of the Insurance Department when such [company] insurer  
220 or entity is examined outside the state.

221 (i) Nothing contained in this section shall prevent or be construed as  
222 prohibiting the commissioner from disclosing the content of an  
223 examination report, preliminary examination report or results, or any  
224 matter relating thereto, to the Insurance Department of this or any  
225 other state or country, or to law enforcement officials of this or any  
226 other state or to any agency of the federal government at any time, so  
227 long as such agency or office receiving the report or matters relating  
228 thereto agrees, in writing, to hold such report and matters relating  
229 thereto confidential.

230 (j) All workpapers, recorded information, documents and copies  
231 thereof produced by, obtained by or disclosed to the commissioner or  
232 any other person in the course of an examination made under this  
233 section shall be [given] confidential, [treatment,] shall not be subject to  
234 subpoena and shall not be made public by the commissioner or any  
235 other person, except to the extent provided in subsection (i) of this  
236 section. The commissioner may grant access to such workpapers,  
237 recorded information, documents and copies thereof to the National  
238 Association of Insurance Commissioners, provided said association  
239 agrees, in writing, to hold such workpapers, recorded information,  
240 documents and copies thereof confidential.

241 (k) (1) The commissioner may from time to time engage, on an  
242 individual basis, the services of qualified actuaries, certified public



243 accountants or other similar individuals who are independently  
244 practicing their professions, even though said persons may from time  
245 to time be similarly employed or retained by persons subject to  
246 examination under this section.

247 (2) No cause of action shall arise nor shall any liability be imposed  
248 against the commissioner, the commissioner's authorized  
249 representatives or any examiner appointed by the commissioner for  
250 any statements made or conduct performed in good faith while  
251 carrying out the provisions of this section.

252 (3) No cause of action shall arise, nor shall any liability be imposed  
253 against any person for the act of communicating or delivering  
254 information or data to the commissioner or the commissioner's  
255 authorized representative examiner pursuant to an examination made  
256 under this section, if such act of communication or delivery was  
257 performed in good faith and without fraudulent intent or the intent to  
258 deceive.

259 (4) This section shall not abrogate or modify in any way any  
260 common law or statutory privilege or immunity heretofore enjoyed by  
261 any person identified in subdivision (2) of this subsection.

262 (5) A person identified in subdivision (2) of this subsection shall be  
263 entitled to an award of attorney's fees and costs if such person is the  
264 prevailing party in a civil action for libel, slander or any other relevant  
265 tort arising out of activities in carrying out the provisions of this  
266 section and the party bringing the action was not substantially justified  
267 in doing so. For purposes of this section, a proceeding is "substantially  
268 justified" if it had a reasonable basis in law or fact at the time that it  
269 was initiated.

270 Sec. 5. Subsection (b) of section 38a-48 of the general statutes is  
271 repealed and the following is substituted in lieu thereof (*Effective*  
272 *October 1, 2017*):

273 (b) On or before July thirty-first, annually, the Insurance

274 Commissioner and the Office of the Healthcare Advocate shall render  
275 to each domestic insurance company or other domestic entity liable for  
276 payment under section 38a-47: [ (1) a] (1) A statement [which] that  
277 includes (A) the amount appropriated to the Insurance Department  
278 and the Office of the Healthcare Advocate for the fiscal year beginning  
279 July first of the same year, (B) the cost of fringe benefits for department  
280 and office personnel for such year, as estimated by the Comptroller,  
281 (C) the estimated expenditures on behalf of the department and the  
282 office from the Capital Equipment Purchase Fund pursuant to section  
283 4a-9 for such year, and (D) the amount appropriated to the  
284 Department on Aging for the fall prevention program established in  
285 section 17a-303a from the Insurance Fund for the fiscal year; [.] (2) a  
286 statement of the total taxes imposed on all domestic insurance  
287 companies and domestic insurance entities under chapter 207 on  
288 business done in this state during the preceding calendar year; [.] and  
289 (3) the proposed assessment against that company or entity, calculated  
290 in accordance with the provisions of subsection (c) of this section,  
291 provided [that] for the purposes of this calculation the amount  
292 appropriated to the Insurance Department and the Office of the  
293 Healthcare Advocate plus the cost of fringe benefits for department  
294 and office personnel and the estimated expenditures on behalf of the  
295 department and the office from the Capital Equipment Purchase Fund  
296 pursuant to section 4a-9 shall be deemed to be the actual expenditures  
297 of the department and the office, and the amount appropriated to the  
298 Department on Aging from the Insurance Fund for the fiscal year for  
299 the fall prevention program established in section 17a-303a shall be  
300 deemed to be the actual expenditures for the program.

301 Sec. 6. Subdivision (2) of subsection (d) of section 38a-78 of the  
302 general statutes is repealed and the following is substituted in lieu  
303 thereof (*Effective October 1, 2017*):

304 (2) Except as otherwise provided in subsections (e), (f) and (l) of this  
305 section, the minimum standard for the valuation of all such policies  
306 and contracts issued prior to the effective date specified in accordance  
307 with the provisions of subsection (h) of section 38-130e of the general

308 statutes, revision of 1958, revised to 1981, shall be that provided by the  
309 laws in effect immediately prior to such date, except that the minimum  
310 standard for the valuation of annuities and pure endowments  
311 purchased prior to January 1, 1973, under group annuity and pure  
312 endowment contracts shall be the 1971 Group Annuity Mortality  
313 Table, or any modification of this table approved by the commissioner,  
314 and an interest rate of five per cent per annum. Except as otherwise  
315 provided in subsections (e), (f) and (l) of this section, the minimum  
316 standard for the valuation of all such policies and contracts issued on  
317 and after such effective date shall be the commissioners' reserve  
318 valuation methods defined in subsections (g), (h) and (j) of this section,  
319 with four and one-half per cent interest and the following tables: (A)  
320 For all ordinary policies of life insurance issued on the standard basis,  
321 excluding any disability and accidental death benefits in such policies,  
322 the Commissioners' 1958 Standard Ordinary Mortality Table for such  
323 policies issued prior to the compliance date established by subdivision  
324 (11) of subsection (e) of section 38a-439, as amended by this act,  
325 provided [that] for any category of such policies issued on female  
326 risks, all modified net premiums and present values referred to in this  
327 section may be calculated according to an age not more than six years  
328 younger than the actual age of the insured and for such policies issued  
329 on or after the compliance date established by subdivision (11) of  
330 subsection (e) of section 38a-439, as amended by this act, (i) the  
331 Commissioners' 1980 Standard Ordinary Mortality Table, (ii) at the  
332 election of the company for any one or more specified plans of life  
333 insurance, the Commissioners' 1980 Standard Ordinary Mortality  
334 Table with ten-year select mortality factors, (iii) on or after January 1,  
335 2005, until January 1, 2009, at the election of the company for any one  
336 or more specified plans of life insurance issued on or after January 1,  
337 2004, on the basis of the Commissioners' 2001 Standard Ordinary  
338 Mortality Table, except that with respect to such plans issued before  
339 April 1, 2005, such mortality table shall be used solely for the basis of  
340 valuation and nonforfeiture and shall not be used to increase the  
341 previously agreed required premium, (iv) issued on or after January 1,  
342 2009, the Commissioners' 2001 Standard Ordinary Mortality Table, or

343 (v) any ordinary mortality table, adopted after 1980 by the National  
344 Association of Insurance Commissioners, that is approved by  
345 regulations adopted by the commissioner in accordance with the  
346 provisions of chapter 54 for use in determining the minimum standard  
347 of valuation for such policies; (B) for all industrial life insurance  
348 policies issued on the standard basis, excluding any disability and  
349 accidental death benefits in such policies, the Commissioners' 1961  
350 Standard Industrial Mortality Table or any industrial mortality table,  
351 adopted after 1980 by the National Association of Insurance  
352 Commissioners, that is approved by regulations adopted by the  
353 commissioner in accordance with the provisions of chapter 54 for use  
354 in determining the minimum standard of valuation for such policies;  
355 (C) for total and permanent disability benefits in or supplementary to  
356 ordinary policies or contracts, the tables of period 2 disablement rates  
357 and the 1930 to 1950 termination rates of the 1952 Disability Study of  
358 the Society of Actuaries, with due regard to the type of benefit or any  
359 tables of disablement rates and termination rates, adopted after 1980  
360 by the National Association of Insurance Commissioners, that are  
361 approved by regulations adopted by the commissioner in accordance  
362 with the provisions of chapter 54 for use in determining the minimum  
363 standard of valuation for such policies. These tables shall, for active  
364 lives, be combined with a mortality table permitted for calculating the  
365 reserves for life insurance policies; (D) for accidental death benefits in  
366 or supplementary to policies, the 1959 Accidental Death Benefits Table  
367 or any accidental death benefits table, adopted after 1980 by the  
368 National Association of Insurance Commissioners, that is approved by  
369 regulations adopted by the commissioner in accordance with the  
370 provisions of chapter 54 for use in determining the minimum standard  
371 of valuation for such policies. These tables shall be combined with a  
372 mortality table permitted for calculating the reserves for life insurance  
373 policies; and (E) for group life insurance, life insurance issued on the  
374 substandard basis and other special benefits, such tables as may be  
375 approved by the commissioner.

376 Sec. 7. Subdivision (2) of subsection (g) of section 38a-78 of the  
377 general statutes is repealed and the following is substituted in lieu

378 thereof (*Effective October 1, 2017*):

379       (2) Except as otherwise provided in subsections (h), (j) and (l) of this  
380 section, reserves according to the commissioners' reserve valuation  
381 method, for the life insurance and endowment benefits of policies  
382 providing for a uniform amount of insurance and requiring the  
383 payment of uniform premiums shall be the excess, if any, of the  
384 present value, at the date of valuation, of such future guaranteed  
385 benefits provided for by such policies, over the then present value of  
386 any future modified net premiums therefor. The modified net  
387 premiums for any such policy shall be such uniform percentage of the  
388 respective contract premiums for such benefits that the present value,  
389 at the date of issue of the policy, of all such modified net premiums  
390 shall be equal to the sum of the then present value of such benefits  
391 provided for by the policy and the excess of subparagraph (A) of this  
392 subdivision over subparagraph (B) of this subdivision, as follows: (A)  
393 A net level annual premium equal to the present value, at the date of  
394 issue, of such benefits provided for after the first policy year, divided  
395 by the present value, at the date of issue, of an annuity of one per  
396 annum payable on the first and each subsequent anniversary of such  
397 policy on which a premium falls due; provided such net level annual  
398 premium shall not exceed the net level annual premium on the  
399 nineteen-year premium whole life plan for insurance of the same  
400 amount at an age one year higher than the age at issue of such policy;  
401 and (B) a net one year term premium for such benefits provided for in  
402 the first policy year provided [that] for any life insurance policy issued  
403 on or after January 1, 1985, for which the contract premium in the first  
404 policy year exceeds that of the second year and for which no  
405 comparable additional benefit is provided in the first year for such  
406 excess and which provides an endowment benefit or a cash surrender  
407 value or a combination thereof in an amount greater than such excess  
408 premium, the reserve according to the commissioners' reserve  
409 valuation method as of any policy anniversary occurring on or before  
410 the assumed ending date defined herein as the first policy anniversary  
411 on which the sum of any endowment benefit and any cash surrender  
412 value then available is greater than such excess premium shall, except

413 as otherwise provided in subsection (j) of this section, be the greater of  
414 the reserve as of such policy anniversary calculated as described in this  
415 subsection and the reserve as of such policy anniversary calculated as  
416 described in this subsection but with the value defined in  
417 subparagraph (A) of this subdivision being reduced by fifteen per cent  
418 of the amount of such excess first year premium, all present values of  
419 benefits and premiums being determined without reference to  
420 premiums or benefits provided for by the policy after the assumed  
421 ending date, the policy being assumed to mature on such date as an  
422 endowment, and the cash surrender value provided on such date  
423 being considered as an endowment benefit. In making the above  
424 comparison, the mortality and interest bases stated in subsections (e)  
425 and (f) of this section shall be used. Reserves according to the  
426 commissioners' reserve valuation method for: (i) Life insurance  
427 policies providing for a varying amount of insurance or requiring the  
428 payment of varying premiums; (ii) group annuity and pure  
429 endowment contracts purchased under a retirement plan or plan of  
430 deferred compensation, established or maintained by an employer,  
431 including a partnership or sole proprietorship, or by an employee  
432 organization, or by both, other than a plan providing individual  
433 retirement accounts or individual retirement annuities under Section  
434 408 of the Internal Revenue Code, as now or hereafter amended; (iii)  
435 disability and accidental death benefits in all policies and contracts;  
436 and (iv) all other benefits, except life insurance and endowment  
437 benefits in life insurance policies and benefits provided by all other  
438 annuity and pure endowment contracts, shall be calculated by a  
439 method consistent with the principles of this subsection.

440 Sec. 8. Subdivision (1) of subsection (b) of section 38a-132 of the  
441 general statutes is repealed and the following is substituted in lieu  
442 thereof (*Effective October 1, 2017*):

443 (b) (1) Any public hearing held by the commissioner pursuant to  
444 [subdivision (1) of] subsection (a) of this section shall be held not later  
445 than thirty days after the statement required by section 38a-130 is filed  
446 with the commissioner. The commissioner shall provide at least twenty

447 days' notice of such hearing to the person filing the statement. The  
448 person filing the statement shall (A) provide at least seven days' notice  
449 of such public hearing to the insurance company and to such other  
450 persons as may be designated by the commissioner, (B) publish, in a  
451 manner prescribed by the commissioner, notice of such hearing in a  
452 newspaper of general circulation in the city of Hartford and in such  
453 other municipality as the commissioner may direct, and (C) provide  
454 notice in such other manner as the commissioner deems appropriate  
455 under the circumstances. If any amendment to the statement is filed,  
456 the commissioner may postpone the public hearing for a reasonable  
457 period not to exceed thirty days after the filing of such amendment.

458 Sec. 9. Subparagraph (A) of subdivision (3) of subsection (o) of  
459 section 38a-135 of the general statutes is repealed and the following is  
460 substituted in lieu thereof (*Effective October 1, 2017*):

461 (A) The place of domicile of the member insurance companies of the  
462 internationally active insurance group that [hold] holds the largest  
463 share of such insurance group's premiums, assets or liabilities;

464 Sec. 10. Subdivision (2) of subsection (c) of section 38a-156a of the  
465 general statutes is repealed and the following is substituted in lieu  
466 thereof (*Effective October 1, 2017*):

467 (2) The reorganizing insurer shall mail a notice of the public hearing  
468 to each member at such member's last known mailing address as  
469 shown in the insurer's records. The notice shall (A) be mailed at least  
470 sixty days prior to the date of the hearing, (B) include the date, time,  
471 place and purpose of the hearing, and (C) be accompanied or preceded  
472 by a true and complete copy of the proposed plan of reorganization or  
473 summary thereof approved by the commissioner and any other  
474 explanatory information or materials the commissioner may require. In  
475 addition, the reorganizing insurer shall provide notice of the date,  
476 time, place and purpose of the hearing by publication in three  
477 newspapers having general circulation, one of which shall be in the  
478 county in which the principal office of the reorganizing insurer is  
479 located, and two [which] that shall be in other municipalities within or

480 without the state and approved by the commissioner. Such notice shall  
481 be published not less than fifteen days and not more than sixty days  
482 prior to the hearing and shall be in a form approved by the  
483 commissioner. Any director, officer, employee or member of the  
484 reorganizing insurer shall have the right to appear and be heard at the  
485 hearing.

486 Sec. 11. Subdivision (2) of subsection (c) of section 38a-156j of the  
487 general statutes is repealed and the following is substituted in lieu  
488 thereof (*Effective October 1, 2017*):

489 (2) The converting company shall mail a notice of the public hearing  
490 to each member at such member's last known mailing address as  
491 shown in the company's records. The notice shall (A) be mailed at least  
492 sixty days prior to the date of the hearing, (B) include the date, time,  
493 place and purpose of the hearing, and (C) be accompanied or preceded  
494 by a true and complete copy of the proposed plan of conversion or a  
495 summary thereof approved by the commissioner and any other  
496 explanatory information or materials the commissioner may require. In  
497 addition, the converting company shall provide notice of the date,  
498 time, place and purpose of the hearing by publication in three  
499 newspapers having general circulation, one of which shall be in the  
500 county in which the principal office of the converting company is  
501 located, and two [which] that shall be in other municipalities within or  
502 without the state and approved by the commissioner. Such notice shall  
503 be published not less than fifteen days and not more than sixty days  
504 prior to the hearing and shall be in a form approved by the  
505 commissioner. Any director, officer, employee or member of the  
506 converting company shall have the right to appear and be heard at the  
507 hearing.

508 Sec. 12. Subsections (a) and (b) of section 38a-194 of the general  
509 statutes are repealed and the following is substituted in lieu thereof  
510 (*Effective October 1, 2017*):

511 (a) In the event of an insolvency of a health care center, upon order  
512 of the commissioner, all other carriers that participated in the



513 enrollment process with the insolvent health care center at a group's  
514 last regular enrollment period shall offer such group's subscribers of  
515 the insolvent health care center a thirty-day enrollment period  
516 commencing upon the date of insolvency. Each carrier shall offer such  
517 subscribers of the insolvent health care center the same coverages and  
518 rates that such carrier had offered to the subscribers of the group at its  
519 last regular enrollment period for the remainder of the term of the  
520 original group contract. An open enrollment shall not be required  
521 where the group contract holder participates in a self-insured,  
522 self-funded or other health plan exempt from the regulation of the  
523 commissioner, unless the plan administrator and group contract  
524 holder voluntarily agree to offer a simultaneous open enrollment and  
525 extend coverage under the same enrollment terms and conditions as  
526 are applicable to carriers under sections 38a-175 to [38a-178, inclusive,  
527 subsection (a) of section 38a-179, sections 38a-182 to 38a-185] 38a-183,  
528 inclusive, [38a-187, 38a-188 and] section 38a-192 [to 38a-194, inclusive,]  
529 and the regulations adopted [hereunder] under said sections.

530 (b) If no other carrier has been offered to one or more groups  
531 enrolled in the insolvent health care center, or if the commissioner  
532 determines that the other carrier or carriers lack sufficient health care  
533 delivery resources to assure that health care services will be available  
534 and accessible to all of the group enrollees of the insolvent health care  
535 center, [then] the commissioner shall allocate equitably the insolvent  
536 health care center's group contracts for such groups among all health  
537 care centers [which] that operate within a portion of the insolvent  
538 health care center's service area, taking into consideration the health  
539 care delivery resources of each health care center. Each health care  
540 center, to which a group or groups are so allocated, shall offer such  
541 group or groups the health care center's existing coverage [which] that  
542 is most similar to the group's coverage with the insolvent health care  
543 center at rates determined in accordance with the successor health care  
544 center's existing rating methodology. No offering by a carrier shall be  
545 required where the group contract holder participates in a self-insured,  
546 self-funded or other health plan exempt from regulation by the  
547 commissioner. The commissioner shall also allocate equitably the

548 insolvent health care center's nongroup enrollees who are unable to  
549 obtain other coverage among all health care centers [which] that  
550 operate within a portion of the insolvent health care center's service  
551 area, taking into consideration the health care delivery resources of  
552 each such health care center. Each health care center to which  
553 nongroup enrollees are allocated [,] shall offer each such nongroup  
554 enrollee [,] the health care center's existing coverage for individual [or  
555 conversion] coverage as determined by [his] such nongroup enrollee's  
556 type of coverage in the insolvent health care center at rates determined  
557 in accordance with the successor health care center's existing rating  
558 methodology. Successor health care centers [which] that do not offer  
559 direct nongroup enrollment may aggregate all of the allocated  
560 nongroup enrollees into one group for rating and coverage purposes.

561       Sec. 13. Subsections (b) and (c) of section 38a-199 of the general  
562 statutes are repealed and the following is substituted in lieu thereof  
563 (*Effective October 1, 2017*):

564       (b) A hospital service corporation providing health care benefits to  
565 plan subscribers under the provisions of subsection (a) of this section  
566 may, upon obtaining the approval of the Insurance Commissioner as  
567 provided in section 38a-208: (1) Contract for the coordination of  
568 benefits with other hospital service corporations, medical service  
569 corporations or insurance companies to avoid duplication of benefits  
570 to be provided to its group subscribers; (2) make loans, grants or  
571 provide anything of value to a health care center covering all or part of  
572 the cost of health services provided to members; (3) contract with a  
573 health care center to provide insurance or similar protection to cover  
574 the cost of care provided through health care centers and to provide  
575 coverage in the event of the insolvency of the health care center; and  
576 (4) establish, maintain, own and operate health care centers as a line of  
577 business, provided [that] (A) aggregate investments hereafter made by  
578 such corporation shall not exceed ten per cent of such corporation's  
579 contingency reserve as of the date of the investment; (B) such  
580 investments shall not be repaid or recovered from rates charged by  
581 such corporation for its non-health-care-center lines of business; and

582 (C) the commissioner finds, based upon evidence furnished by such  
583 corporation, that the financial condition of such corporation and the  
584 rates of its non-health-care-center subscribers are not unduly  
585 jeopardized by such investment. Subdivision (1) of this subsection  
586 shall be subject to such regulations as may be adopted by the  
587 Insurance Commissioner, in accordance with the provisions of chapter  
588 54, to establish coordination of benefits clauses in health care contracts.

589 (c) Each hospital service corporation shall maintain reserves equal in  
590 amount to its liabilities under all its policy contracts, as the same are  
591 computed in accordance with regulations adopted in accordance with  
592 the provisions of chapter 54 upon reasonable consideration of  
593 ascertained experience for the purpose of adequately protecting the  
594 subscriber and securing the solvency of such company. Each such  
595 corporation shall maintain a reserve for contingencies that shall not be  
596 less than the amount required by companies licensed to transact  
597 accident and health insurance, under section 38a-72. The commissioner  
598 may adopt regulations, in accordance with the provisions of chapter  
599 54, prescribing the maximum amount that may be held in the reserve  
600 for contingencies, and in adopting such regulations, shall consider the  
601 stability, solvency and interests of the corporation and the interests of  
602 the subscribers and other affected persons. On and after October 1,  
603 1974, the commissioner may require a hospital service corporation to  
604 adjust its reserve for contingencies to comply with the provisions of  
605 this section and to adjust its rates or benefits or both to reflect the  
606 adjustment in the reserve for contingencies.

607 Sec. 14. Subsections (b) and (c) of section 38a-214 of the general  
608 statutes are repealed and the following is substituted in lieu thereof  
609 (*Effective October 1, 2017*):

610 (b) A medical service corporation providing health care benefits to  
611 plan subscribers under the provisions of subsection (a) of this section  
612 may, upon obtaining the approval of the Insurance Commissioner as  
613 provided in section 38a-218: (1) Contract for the coordination of  
614 benefits with other hospital service corporations, medical service

615 corporations or insurance companies to avoid duplication of benefits  
616 to be provided to its group subscribers; (2) make loans, grants or  
617 provide anything of value to a health care center covering all or part of  
618 the cost of health services provided to members; (3) contract with a  
619 health care center to provide insurance or similar protection to cover  
620 the cost of care provided through health care centers and to provide  
621 coverage in the event of the insolvency of the health care center; and  
622 (4) establish, maintain, own and operate health care centers as a line of  
623 business, provided [that] (A) aggregate investments hereafter made by  
624 such corporation shall not exceed ten per cent of such corporation's  
625 contingency reserve as of the date of the investment; (B) such  
626 investments shall not be repaid or recovered from rates charged by  
627 such corporation for its non-health-care-center lines of business; and  
628 (C) the commissioner finds, based upon evidence furnished by such  
629 corporation, that the financial condition of such corporation and the  
630 rates of its non-health-care-center subscribers are not unduly  
631 jeopardized by such investment. Subdivision (1) of this subsection  
632 shall be subject to such regulations as may be adopted by the  
633 Insurance Commissioner, in accordance with the provisions of chapter  
634 54, to establish coordination of benefits clauses in health care benefit  
635 contracts.

636 (c) Each medical service corporation shall maintain reserves equal in  
637 amount to its liabilities under all its policy contracts, as the same are  
638 computed in accordance with regulations adopted in accordance with  
639 the provisions of chapter 54 upon reasonable consideration of  
640 ascertained experience for the purpose of adequately protecting the  
641 subscriber or securing the solvency of such company. Each such  
642 corporation shall maintain a reserve for contingencies that shall not be  
643 less than the amount required by companies licensed to transact  
644 accident and health insurance, under section 38a-72. The commissioner  
645 may adopt regulations, in accordance with the provisions of chapter  
646 54, prescribing the maximum amount that may be held in the reserve  
647 for contingencies, and in adopting such regulations, shall consider the  
648 stability, solvency and interests of the corporation, and the interests of  
649 the subscribers and other affected persons. On and after October 1,

1974, the commissioner may require a medical service corporation to adjust its reserve for contingencies to comply with the provisions of this section and to adjust its rates or benefits or both to reflect such adjustment in the reserve for contingencies.

Sec. 15. Section 38a-236 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

No nonprofit legal service corporation, as defined in section 38a-230, shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval thereof. The commissioner may refuse such approval if [he] the commissioner finds such rates are excessive, inadequate or unfairly discriminatory. No such legal service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until the commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation [either] of [his] the commissioner's approval or disapproval thereof.

Sec. 16. Subdivision (1) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(1) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site [which] that is not owned or controlled by any person who hires an independent contractor to perform that work, and shall include liability for activities [which] that are completed or abandoned before the date of the occurrence giving rise to the liability;

Sec. 17. Subdivision (5) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

682 (5) "Insurance" means primary insurance, excess insurance,  
683 reinsurance, surplus lines insurance and any other arrangement for  
684 shifting and distributing risk [which] that is determined to be  
685 insurance under applicable state or federal law;

686 Sec. 18. Subdivision (12) of section 38a-250 of the general statutes is  
687 repealed and the following is substituted in lieu thereof (*Effective*  
688 *October 1, 2017*):

689 (12) "Risk retention group" means any corporation or other limited  
690 liability association: (A) Whose primary activity consists of assuming  
691 and spreading all, or any portion, of the liability exposure of its group  
692 members; (B) [which] that is organized for the primary purpose of  
693 conducting the activity described under subparagraph (A) of this  
694 subdivision; (C) that (i) is chartered and licensed as a liability  
695 insurance company under the laws of a state and authorized to engage  
696 in the business of insurance under the laws of such state, or (ii) before  
697 January 1, 1985, was chartered or licensed and authorized to engage in  
698 the business of insurance under the laws of Bermuda or the Cayman  
699 Islands and, before said date, had certified to the insurance  
700 commissioner of at least one state that it satisfied the capitalization  
701 requirements of such state, except that any such group shall be  
702 considered to be a risk retention group only if it has been engaged in  
703 business continuously since such date and only for the purpose of  
704 continuing to provide insurance to cover product liability or  
705 completed operations liability, as such terms were defined in the  
706 Product Liability Risk Retention Act of 1981, 15 USC 3901 et seq.,  
707 before the date of the enactment of the Liability Risk Retention Act of  
708 1986; (D) that does not exclude any person from membership in the  
709 group solely to provide for members of such a group a competitive  
710 advantage over such a person; (E) that (i) has as its owners only  
711 persons who comprise the membership of the risk retention group and  
712 who are provided insurance by such group, or (ii) has as its sole owner  
713 an organization [which] that has as its members only persons who  
714 comprise the membership of the risk retention group, and as its  
715 owners only persons who comprise the membership of the risk

716 retention group and who are provided insurance by such group; (F)  
717 whose members are engaged in businesses or activities similar or  
718 related with respect to the liability to which such members are exposed  
719 by virtue of any related, similar or common business, trade, product,  
720 services, premises or operations; (G) whose activities do not include  
721 the provision of insurance other than (i) liability insurance for  
722 assuming and spreading all or any portion of the similar or related  
723 liability exposure of its group members, and (ii) reinsurance with  
724 respect to the similar or related liability exposure of any other risk  
725 retention group, or any member of such other group, that is engaged  
726 in businesses or activities so that such group or member meets the  
727 requirement described in subparagraph (F) of this subdivision for  
728 membership in the risk retention group that provides such  
729 reinsurance; and (H) the name of which includes the phrase "Risk  
730 Retention Group";

731 Sec. 19. Section 38a-262 of the general statutes is repealed and the  
732 following is substituted in lieu thereof (*Effective October 1, 2017*):

733 The Insurance Commissioner is authorized to make use of any of  
734 the powers established under this title to enforce the laws of this state  
735 so long as those powers are not specifically preempted by the Product  
736 Liability Risk Retention Act of 1981, [(15 USC 3901 et seq.)] 15 USC  
737 3901 et seq., as amended by the Liability Risk Retention Act of 1986.  
738 Such authorization includes, but is not limited to, the commissioner's  
739 administrative authority to investigate, issue subpoenas, conduct  
740 depositions and hearings, issue orders and impose penalties. With  
741 regard to any investigation, administrative proceedings or litigation,  
742 the commissioner may rely on the procedural law and regulations of  
743 the state. The injunctive authority of the commissioner in regard to risk  
744 retention groups is restricted by the requirement that any injunction be  
745 issued by a court of competent jurisdiction.

746 Sec. 20. Section 38a-263 of the general statutes is repealed and the  
747 following is substituted in lieu thereof (*Effective October 1, 2017*):

748 Any person acting, or offering to act, as a producer for a risk

749 retention group or purchasing group [which] that solicits members,  
750 sells insurance coverage, purchases coverage for its members located  
751 within the state or otherwise does business in this state shall, before  
752 commencing any such activity, obtain a license from the Insurance  
753 Commissioner in such form as the commissioner prescribes in  
754 accordance with the provisions of section 38a-769.

755 Sec. 21. Section 38a-264 of the general statutes is repealed and the  
756 following is substituted in lieu thereof (*Effective October 1, 2017*):

757 A risk retention group [which] that violates any provision of  
758 sections 38a-250 to 38a-266, inclusive, as amended by this act, shall be  
759 subject to fines and penalties applicable to licensed insurers generally,  
760 including revocation of its license and the right to do business in this  
761 state.

762 Sec. 22. Subsection (b) of section 38a-308 of the general statutes is  
763 repealed and the following is substituted in lieu thereof (*Effective*  
764 *October 1, 2017*):

765 (b) Any policy or contract that includes, either on an unspecified  
766 basis as to coverage or for an indivisible premium, coverage against  
767 the peril of fire and substantial coverage against other perils need not  
768 comply with the provisions of subsection (a) of this section, provided:  
769 (1) Such policy or contract shall afford coverage, with respect to the  
770 peril of fire, not less than the substantial equivalent of the coverage  
771 afforded by said standard fire insurance policy; (2) except as provided  
772 under subdivision (1) of subsection (a) of this section for a policy or  
773 contract of fire insurance for a commercial property made, issued or  
774 delivered by a [surplus lines] nonadmitted insurer or any agent or  
775 representative thereof, the following provisions in said standard fire  
776 insurance policy are incorporated therein without change: (A)  
777 Mortgagee interests and obligations, (B) the definitions of actual cash  
778 value and depreciation, (C) the time period for when a loss is payable  
779 after proof of loss, and (D) the time period for when a suit or action for  
780 the recovery of a claim may be commenced; (3) such policy or contract  
781 is complete as to all of its terms without reference to any other



782 document; and (4) the commissioner is satisfied that such policy or  
783 contract complies with the provisions hereof. The provisions of this  
784 subsection shall apply to any such policy or contract issued or renewed  
785 on or after July 1, 2014.

786 Sec. 23. Section 38a-310 of the general statutes is repealed and the  
787 following is substituted in lieu thereof (*Effective October 1, 2017*):

788 Two or more insurers authorized to do the business of property  
789 insurance in this state may, with the approval of the commissioner,  
790 issue a combination standard form of fire insurance policy [which] that  
791 shall contain the following provisions: [(a)] (1) A provision  
792 substantially to the effect that the insurers executing such policy shall  
793 be severally liable for the full amount of any loss or damage, according  
794 to the terms of the policy, or for specified percentages or amounts  
795 thereof, aggregating the full amount of such insurance under such  
796 policy; [(b)] and (2) a provision substantially to the effect that service of  
797 process, or of any notice or proof of loss required by such policy, upon  
798 any of the insurers executing such policy, shall be deemed to be service  
799 upon all such insurers.

800 Sec. 24. Section 38a-311 of the general statutes is repealed and the  
801 following is substituted in lieu thereof (*Effective October 1, 2017*):

802 [Appropriate] The commissioner may approve appropriate forms of  
803 supplemental contract or contracts or extended coverage endorsements  
804 and additional contracts or endorsements, in addition to the perils  
805 covered [by said] under a standard fire insurance policy, [may be  
806 approved by the commissioner] and their use in connection with a  
807 standard fire insurance policy. [may be authorized by him.] The first  
808 page of the policy may, in form approved by the commissioner, be  
809 rearranged to provide space for the listing of amounts of insurance,  
810 rates and premiums for the basic coverages insured under the  
811 standard form of policy and for additional coverages or perils insured  
812 under supplemental or additional contracts or endorsements, and such  
813 other data as may be conveniently included for duplication on daily  
814 reports for office records.

815 Sec. 25. Section 38a-323b of the general statutes is repealed and the  
816 following is substituted in lieu thereof (*Effective October 1, 2017*):

817 Each insurer, or designee of an insurer, that denies a claim under a  
818 personal risk insurance policy issued in this state shall provide the  
819 insured with written notice of the denial. The written notice shall  
820 include the following statement, which shall appear in the final  
821 paragraph of the notice in not less than twelve point type: "If you do  
822 not agree with this decision, you may contact the Division of  
823 Consumer Affairs within the Insurance Department". The notice shall  
824 include the address and toll-free telephone number for the division  
825 and the Insurance Department's Internet web site address. As used in  
826 this section, "personal risk insurance" [means personal risk insurance,  
827 as defined] has the same meaning as provided in section 38a-663.

828 Sec. 26. Section 38a-341 of the general statutes is repealed and the  
829 following is substituted in lieu thereof (*Effective October 1, 2017*):

830 As used in sections 38a-341 to 38a-346, inclusive, as amended by this  
831 act:

832 (1) "Policy" means an automobile liability insurance policy  
833 providing among other coverage bodily injury liability, delivered or  
834 issued for delivery in this state, insuring a single individual or spouses  
835 resident of the same household, as named insured, and under which  
836 the insured vehicles therein designated are of the following types only:  
837 (A) A motor vehicle of the private passenger or station wagon type  
838 that is not used as a public or livery conveyance for passengers, nor  
839 rented to others, or (B) any other four-wheel motor vehicle with a load  
840 capacity of fifteen hundred pounds or less [which] that is not used in  
841 the occupation, profession or business of the insured, provided said  
842 sections shall not apply to (i) [to] any policy insuring more than four  
843 automobiles, [or] (ii) [to] any policy covering garage, automobile sales  
844 agency, repair shop, service station or public parking place operation  
845 hazards, or (iii) [to] any policy of insurance issued principally to cover  
846 personal or premises liability of an insured even though the insurance  
847 may also provide some incidental coverage for liability arising out of

848 the ownership, maintenance or use of a motor vehicle on the premises  
849 of the insured or on the ways immediately adjoining the premises;

850 (2) "Renewal" or "to renew" means the issuance and delivery by an  
851 insurer of a policy replacing at the end of the policy period a policy  
852 previously issued and delivered by the same insurer, or the issuance  
853 and delivery of a certificate or notice extending the term of the policy  
854 beyond its policy period or term. Any policy with a policy period or  
855 term of less than six months shall, for the purpose of sections 38a-341  
856 to 38a-346, inclusive, as amended by this act, be considered as if  
857 written for a policy period or term of six months and any policy  
858 written for a term longer than one year or any policy with no fixed  
859 expiration date, shall for the purpose of said sections, be considered as  
860 if written for successive policy periods or terms of one year. Such a  
861 policy may be terminated at the expiration of any annual period upon  
862 giving thirty days' notice of cancellation prior to the anniversary date,  
863 and such cancellation shall not be subject to any other provisions of  
864 said sections;

865 (3) "Nonpayment of premium" means failure of the named insured  
866 to discharge when due any of [his] such insured's obligations in  
867 connection with the payment of premiums on the policy, or any  
868 installment of such premium, whether the premium is payable directly  
869 to the insurer or its agent or indirectly under any premium finance  
870 plan or extension of credit. Nonpayment of premium includes, but is  
871 not limited to, the dishonor of any check, draft or other remittance  
872 upon presentment for payment;

873 (4) "Declination" means: (A) With respect to a producer, denial in  
874 whole or in part of an applicant's written request for coverage; failure  
875 to submit within a reasonable period of time a completed written  
876 application for coverage to a specific insurer [which] that the producer  
877 represents or with which the producer has an account and [which] that  
878 is requested in writing by the applicant; placement of a risk with a  
879 residual market, an unauthorized insurer, or an insurer [which] that  
880 specializes in substandard risks; or refusal to provide, upon written

881 request, an application for coverage; (B) with respect to an insurer  
882 [which] that conducts its business through independent licensed  
883 insurance producers, refusal to issue a policy after receipt of a  
884 completed written application for coverage from a producer who  
885 represents it or from a producer with whom it has an account; or (C)  
886 with respect to an insurer other than one specified in subparagraph (B)  
887 of this subdivision, refusal to issue a policy after receipt of a completed  
888 written application, or refusal to provide, upon written request, an  
889 application for coverage.

890 Sec. 27. Section 38a-343 of the general statutes is repealed and the  
891 following is substituted in lieu thereof (*Effective October 1, 2017*):

892 (a) No notice of cancellation of a policy to which section 38a-342  
893 applies shall be effective unless sent, by registered or certified mail or  
894 by mail evidenced by a certificate of mailing, or delivered by the  
895 insurer to the named insured, and any third party designated pursuant  
896 to section 38a-323a, at least forty-five days before the effective date of  
897 cancellation, except that (1) where cancellation is for nonpayment of  
898 the first premium on a new policy, at least fifteen days' notice of  
899 cancellation accompanied by the reason for cancellation shall be given,  
900 and (2) where cancellation is for nonpayment of any other premium, at  
901 least ten days' notice of cancellation accompanied by the reason for  
902 cancellation shall be given. No notice of cancellation of a policy that  
903 has been in effect for less than sixty days shall be effective unless  
904 mailed or delivered by the insurer to the insured and any third party  
905 designee at least forty-five days before the effective date of  
906 cancellation, except that (A) at least fifteen days' notice shall be given  
907 where cancellation is for nonpayment of the first premium on a new  
908 policy, and (B) at least ten days' notice shall be given where  
909 cancellation is for nonpayment of any other premium or material  
910 misrepresentation. The notice of cancellation shall state or be  
911 accompanied by a statement specifying the reason for such  
912 cancellation. Any notice of cancellation for nonpayment of the first  
913 premium on a new policy may be retroactive to the effective date of  
914 such policy, provided at least fifteen days' notice has been given to the

915 insured and any third party designee and payment of such premium  
916 has not been received during such notice period.

917 (b) Where [a private passenger motor vehicle liability insurance  
918 company] an insurer sends a notice of cancellation under subsection  
919 (a) of this section to the named insured of a [private passenger motor  
920 vehicle liability insurance] policy, or a third party designee, such  
921 company shall provide with such notice a warning, in a form  
922 approved by the Commissioner of Motor Vehicles and the Insurance  
923 Commissioner, that informs the named insured that (1) the  
924 cancellation will be reported to the Commissioner of Motor Vehicles;  
925 (2) the named insured may be receiving one or more mail inquiries  
926 from the Commissioner of Motor Vehicles, concerning whether or not  
927 required insurance coverage is being maintained, and that the named  
928 insured must respond to these inquiries; (3) if the required insurance  
929 coverage lapses at any time, the Commissioner of Motor Vehicles may  
930 suspend the registration or registrations for the vehicle or vehicles  
931 under the policy and the number plates will be subject to confiscation  
932 and any person operating any such vehicle will be subject to legal  
933 penalties for operating a motor vehicle with a suspended registration;  
934 and (4) the named insured will not be able to have the registration  
935 restored or obtain a new registration, or any other registration or  
936 renewal in the insured's name, except upon presentation to the  
937 Commissioner of Motor Vehicles of evidence of required security or  
938 coverage and the entering into of a consent agreement with the  
939 commissioner in accordance with the provisions of section 14-12g.

940 (c) If [a passenger motor vehicle liability insurance company] an  
941 insurer cancels a [private passenger motor vehicle liability insurance]  
942 policy pursuant to section 38a-342, such [company] insurer shall send a  
943 written notice of such cancellation to any lienholder shown on the  
944 records of such [company] insurer as having a legal interest in such  
945 motor vehicle.

946 (d) Subsections (a) and (b) of this section shall not apply to  
947 nonrenewal or if the [private passenger motor vehicle liability

948 insurance] policy is transferred from an insurer to an affiliate of such  
949 insurer for another policy with no interruption of coverage and  
950 contains the same terms, conditions and provisions, including policy  
951 limits, as the transferred policy, except that the insurer to which the  
952 policy is transferred shall not be prohibited from applying its rates and  
953 rating plans at the time of renewal.

954 (e) No [insurance company] insurer that renews, amends or  
955 endorses in this state a [private passenger motor vehicle liability  
956 insurance] policy shall charge any fee or other charge exceeding one  
957 hundred dollars in the aggregate to an insured who cancels such  
958 policy prior to the expiration of such policy.

959 Sec. 28. Section 38a-343a of the general statutes is repealed and the  
960 following is substituted in lieu thereof (*Effective October 1, 2017*):

961 (a) (1) The Commissioner of Motor Vehicles may require each  
962 [insurance company] insurer that issues [private passenger motor  
963 vehicle liability insurance] policies in this state to notify [the] said  
964 commissioner monthly, on a date specified by [the] said commissioner,  
965 of the cancellation by the [insurance company] insurer of all such  
966 policies [which] that occurred during the preceding month. Such  
967 notice shall include the name of the named insured in the policy, the  
968 policy number, the vehicle identification number of each automobile  
969 covered by the policy and the effective date of the policy's cancellation.  
970 [The] Said commissioner shall specify an acceptable method of  
971 notification. The method of notification specified may include  
972 computer tapes or electronic transmission.

973 (2) [The] Said commissioner may require each [insurance company]  
974 insurer that issues [private passenger motor vehicle liability insurance]  
975 policies in this state to provide monthly, on a date specified by [the]  
976 said commissioner, the policy information required for purposes of the  
977 Online Insurance Verification System, as provided in section 14-112a.

978 (3) The failure of an [insurance company] insurer to comply with  
979 the requirements of this section shall not affect the cancellation of any

980 [private passenger motor vehicle liability insurance] policy.

981 (b) The Commissioner of Motor Vehicles shall receive or accept all  
982 notices of policy cancellation or all policy information from [private  
983 passenger motor vehicle liability insurance companies] insurers, as  
984 required pursuant to subsection (a) of this section. [The] Said  
985 commissioner shall review and analyze the cancellation data or policy  
986 information submitted, together with such other information as [the]  
987 said commissioner may obtain from the [private passenger motor  
988 vehicle liability insurance companies] insurers, from the records of the  
989 Department of Motor Vehicles, or from any other public or private  
990 agency or firm in possession of relevant information, for the purpose  
991 of determining whether any registered owner identified in any such  
992 notice has failed to continuously maintain insurance coverage in  
993 violation of sections 14-12c and 38a-371, as amended by this act. In  
994 conducting such an inquiry to determine insured status, [the] said  
995 commissioner may contact registered vehicle owners by mail and  
996 require that such mail inquiries be answered in not less than thirty  
997 days, in a satisfactory manner containing such information and  
998 verification of insurance coverage as [the] said commissioner [shall  
999 deem] deems necessary and acceptable.

1000 Sec. 29. Section 38a-345 of the general statutes is repealed and the  
1001 following is substituted in lieu thereof (*Effective October 1, 2017*):

1002 When automobile bodily injury and property damage liability  
1003 coverage is cancelled, other than for nonpayment of premium, or in the  
1004 event of failure to renew the policy as provided in section 38a-323, the  
1005 insurer shall notify the named insured of [his] such insured's possible  
1006 eligibility for automobile liability insurance through the automobile  
1007 liability assigned risk plan. Such notice shall accompany or be included  
1008 in the notice of cancellation or the notice of intent not to renew.

1009 Sec. 30. Subsection (f) of section 38a-371 of the general statutes is  
1010 repealed and the following is substituted in lieu thereof (*Effective*  
1011 *October 1, 2017*):

1012 (f) Upon receipt of a signed written request for suspension from the  
1013 owner of a registered motor vehicle stating that such vehicle will not  
1014 be operated upon any highway during a period of not less than thirty  
1015 consecutive days, the insurer of such vehicle shall suspend, to the  
1016 extent requested by the owner, insurance coverage afforded under the  
1017 policy providing the security required by sections 38a-363 to 38a-388,  
1018 inclusive, for such vehicle until notified by the owner that the coverage  
1019 should be reinstated. During the period of suspension only, the  
1020 provisions of subsections (a) to (e), inclusive, of this section shall not  
1021 apply with respect to such vehicle, [provided,] except that if such  
1022 vehicle is operated upon any highway by or with the permission of the  
1023 owner during the period of suspension, the provisions of said  
1024 subsections (a) to (e), inclusive, of this section, shall thereupon become  
1025 applicable. As used in this subsection, "highway" [shall be defined] has  
1026 the same meaning as provided in section 14-1. This subsection shall not  
1027 apply to a motor vehicle for which proof of financial responsibility is  
1028 required under the provisions of sections 14-112 to 14-133, inclusive.

1029 Sec. 31. Subsection (a) of section 38a-433 of the general statutes is  
1030 repealed and the following is substituted in lieu thereof (*Effective*  
1031 *October 1, 2017*):

1032 (a) A domestic life insurance company, including for the purposes  
1033 of this section all domestic fraternal benefit societies [which] that  
1034 operate on a legal reserve basis, may establish one or more separate  
1035 accounts and may allocate thereto amounts, including without  
1036 limitation proceeds applied under optional modes of settlement or  
1037 under dividend options, to provide for life insurance or life or period-  
1038 certain annuities, and benefits incidental thereto, payable in fixed or  
1039 variable amounts or both, or to accumulate funds [which] that are paid  
1040 to or held by such company pursuant to section 38a-459, subject to the  
1041 following: (1) The income, gains and losses, realized or unrealized,  
1042 from assets allocated to a separate account shall be credited to or  
1043 charged against the account, without regard to other income, gains or  
1044 losses of the company; (2) except as may be provided with respect to  
1045 reserves for guaranteed benefits and funds referred to in subdivision



1046 (3) of this subsection, amounts allocated to any separate account and  
1047 accumulations thereon may be invested and reinvested in any class of  
1048 loans and investments, and such loans and investments shall not be  
1049 included in applying the limitations provided in sections 38a-102 to  
1050 38a-102h, inclusive; (3) except with the approval of the commissioner  
1051 and under such conditions as to investments and other matters as [he]  
1052 the commissioner may prescribe, which shall recognize the guaranteed  
1053 nature of the benefits provided, reserves for (A) benefits guaranteed as  
1054 to dollar amount and duration, and (B) funds guaranteed as to  
1055 principal amount or stated rate of interest shall not be maintained in a  
1056 separate account; (4) unless otherwise approved by the commissioner,  
1057 assets allocated to a separate account shall be valued at their market  
1058 value on the date of valuation, or if there is no readily available  
1059 market, then as provided under the terms of the contract or the rules or  
1060 other written agreement applicable to such separate account, provided,  
1061 that unless otherwise approved by the commissioner, the portion, if  
1062 any, of the assets of such separate account equal to the company's  
1063 reserve liability with regard to the guaranteed benefits and funds  
1064 referred to in subdivision (3) of this subsection [,] shall be valued in  
1065 accordance with the rules otherwise applicable to the company's  
1066 assets; (5) amounts allocated to a separate account in the exercise of the  
1067 power granted by this section shall be owned by the company [,] and  
1068 the company shall not be, nor hold itself out to be, a trustee with  
1069 respect to such amounts. If, and to the extent so provided under the  
1070 applicable contracts, that portion of the assets of any such separate  
1071 account equal to the reserves and other contract liabilities with respect  
1072 to such account shall not be chargeable with liabilities arising out of  
1073 any other business the company may conduct; (6) no sale, exchange or  
1074 other transfer of assets may be made by a company between any of its  
1075 separate accounts or between any other investment account and one or  
1076 more of its separate accounts unless, in case of a transfer into a  
1077 separate account, such transfer is made solely to establish the account  
1078 or to support the operation of the contracts with respect to the separate  
1079 account to which the transfer is made, and unless such transfer,  
1080 whether into or from a separate account, is made (A) by a transfer of

1081 cash, or (B) by a transfer of securities having a readily determinable  
1082 market value, provided [that] such transfer of securities is approved by  
1083 the commissioner. The commissioner may approve other transfers  
1084 among such accounts if, in [his] the commissioner's opinion, such  
1085 transfers would not be inequitable; (7) to the extent such company  
1086 deems it necessary to comply with any applicable federal or state laws,  
1087 such company, with respect to any separate account, including  
1088 without limitation any separate account [which] that is a management  
1089 investment account or a unit investment trust, may provide for  
1090 persons having an interest therein appropriate voting and other rights  
1091 and special procedures for the conduct or the business of such account,  
1092 including without limitation special rights and procedures relating to  
1093 investment policy, investment advisory services, selection of  
1094 independent public accountants [,] and the selection of a committee,  
1095 the members of which need not be otherwise affiliated with such  
1096 company, to manage the business of such account. The provisions of  
1097 this subsection shall apply notwithstanding any inconsistent provision  
1098 in the charter of any such domestic life insurance company or in the  
1099 general statutes.

1100 Sec. 32. Subsection (b) of section 38a-439 of the general statutes is  
1101 repealed and the following is substituted in lieu thereof (*Effective*  
1102 *October 1, 2017*):

1103 (b) Any cash surrender value available under the policy in the event  
1104 of default in a premium payment due on any policy anniversary,  
1105 whether or not required by subsection (a) of this section, shall be an  
1106 amount not less than the excess, if any, of the present value, on such  
1107 anniversary, of the future guaranteed benefits [which] that would have  
1108 been provided for by the policy, including any existing paid-up  
1109 additions, if there had been no default, over the sum of: (1) The then  
1110 present value of the adjusted premiums as defined in subsections (d)  
1111 and (e) of this section, corresponding to premiums [which] that would  
1112 have become due on and after such anniversary, and (2) the amount of  
1113 any indebtedness to the company on the policy; provided, [that] for  
1114 any policy issued on or after the compliance date established by

1115 subdivision (11) of subsection (e) of this section [, which] that provides  
1116 supplemental life insurance or annuity benefits at the option of the  
1117 insured and for an identifiable additional premium by rider or  
1118 supplemental policy provision, the cash surrender value shall be an  
1119 amount not less than the sum of such value for an otherwise similar  
1120 policy issued at the same age without such rider or supplemental  
1121 policy provision and for a policy [which] that provides only the  
1122 benefits otherwise provided by such rider or supplemental policy  
1123 provision; provided [,] further, [that] for any family policy issued on or  
1124 after the compliance date established by subdivision (11) of subsection  
1125 (e) of this section [, which] that defines a primary insured and provides  
1126 term insurance on the life of the spouse of the primary insured  
1127 expiring before the spouse attains the age of seventy-one, the cash  
1128 surrender value shall be an amount not less than the sum of such value  
1129 for an otherwise similar policy issued at the same age without such  
1130 term insurance on the life of the spouse and for a policy [which] that  
1131 provides only the benefits otherwise provided by such term insurance  
1132 on the life of the spouse. Any cash surrender value available within  
1133 thirty days after any policy anniversary under any policy paid-up by  
1134 completion of all premium payments or any policy continued under  
1135 any paid-up nonforfeiture benefit, whether or not required by  
1136 subsection (a) of this section, shall be an amount not less than the  
1137 present value, on such anniversary, of the future guaranteed benefits  
1138 provided for by the policy, including any existing paid-up additions,  
1139 decreased by any indebtedness to the company on the policy.

1140 Sec. 33. Subsection (e) of section 38a-439 of the general statutes is  
1141 repealed and the following is substituted in lieu thereof (*Effective*  
1142 *October 1, 2017*):

1143 (e) The provisions of this subsection shall apply to all policies issued  
1144 on or after the compliance date established by subdivision (11) of this  
1145 subsection. (1) Except as provided in subdivision (7) of this subsection,  
1146 the adjusted premiums for any policy shall be calculated on an annual  
1147 basis and shall be such uniform percentage of the respective premiums  
1148 specified in the policy for each policy year, excluding amounts payable

1149 as extra premiums to cover impairments or special hazards and also  
1150 excluding any uniform annual contract charge or policy fee specified  
1151 in the policy in a statement of the method used in calculating the cash  
1152 surrender values and paid-up nonforfeiture benefits, that the present  
1153 value, at the date of issue of the policy, of all adjusted premiums shall  
1154 be equal to the sum of: (A) The then present value of the future  
1155 guaranteed benefits provided for by the policy; (B) one per cent of  
1156 either the amount of insurance, if the insurance be uniform in amount,  
1157 or the average amount of insurance at the beginning of each of the first  
1158 ten policy years; and (C) one hundred twenty-five per cent of the  
1159 nonforfeiture net level premium as hereinafter defined, provided [that]  
1160 in applying the percentage specified in this subparagraph, no  
1161 nonforfeiture net level premium shall be deemed to exceed four per  
1162 cent of either the amount of insurance, if the insurance be uniform in  
1163 amount, or the average amount of insurance at the beginning of each  
1164 of the first ten policy years. The date of issue of a policy for the  
1165 purpose of this subsection shall be the date as of which the rated age of  
1166 the insured is determined; (2) the nonforfeiture net level premium  
1167 shall be equal to the present value, at the date of issue of the policy, of  
1168 the guaranteed benefits divided by the present value, at such date of  
1169 issue, of an annuity of one per annum payable on the date of issue of  
1170 the policy and on each anniversary of such policy on which a premium  
1171 becomes due; (3) in the case of policies that, on a basis guaranteed in  
1172 the policy, provide for unscheduled changes in benefits or premiums,  
1173 or that provide an option for changes in benefits or premiums other  
1174 than a change to a new policy, the adjusted premiums and present  
1175 values shall initially be calculated on the assumption that future  
1176 benefits and premiums do not change from those stipulated at the date  
1177 of issue of the policy. At the time of any such change in the benefits or  
1178 premiums the future adjusted premiums, nonforfeiture net level  
1179 premiums and present values shall be recalculated on the assumption  
1180 that future benefits and premiums do not change from those stipulated  
1181 by the policy immediately after the change; (4) except as otherwise  
1182 provided in subdivision (7) of this subsection, the recalculated future  
1183 adjusted premiums for any such policy shall be the uniform

1184 percentage of the respective future premiums specified in the policy  
1185 for each policy year, excluding amounts payable as extra premiums to  
1186 cover impairments and special hazards, and also excluding any  
1187 uniform annual contract charge or policy fee specified in the policy in a  
1188 statement of the method used in calculating the cash surrender values  
1189 and paid-up nonforfeiture benefits, that the present value, at the time  
1190 of change to the newly defined benefits or premiums, of all such future  
1191 adjusted premiums shall be equal to the excess of (A) the sum of: (i)  
1192 The then present value of the future guaranteed benefits provided for  
1193 by the policy and (ii) the additional expense allowance, if any, over (B)  
1194 the then cash surrender value, if any, or present value of any paid-up  
1195 nonforfeiture benefit under the policy; (5) the additional expense  
1196 allowance, at the time of the change to the newly defined benefits or  
1197 premiums, shall be the sum of (A) one per cent of the excess, if  
1198 positive, of the average amount of insurance at the beginning of each  
1199 of the first ten policy years subsequent to the change over the average  
1200 amount of insurance prior to the change at the beginning of each of the  
1201 first ten policy years subsequent to the time of the most recent  
1202 previous change, or, if there has been no previous change, the date of  
1203 issue of the policy; and (B) one hundred twenty-five per cent of the  
1204 increase, if positive, in the nonforfeiture net level premium; (6) the  
1205 recalculated nonforfeiture net level premium shall be equal to the  
1206 amount obtained by dividing (A) by (B) where (A) equals the sum of  
1207 (i) the nonforfeiture net level premium applicable prior to the change,  
1208 multiplied by the present value of an annuity of one per annum  
1209 payable on each anniversary of the policy on or subsequent to the date  
1210 of change on which a premium would have become due had the  
1211 change not occurred, and (ii) the present value of the increase in future  
1212 guaranteed benefits provided for by the policy, and (B) equals the  
1213 present value of an annuity of one per annum payable on each  
1214 anniversary of the policy on or subsequent to the date of change on  
1215 which a premium becomes due; (7) notwithstanding any other  
1216 provisions of this subsection, in the case of a policy issued on a  
1217 substandard basis that provides reduced graded amounts of insurance  
1218 so that, in each policy year, such policy has the same tabular mortality

1219 cost as an otherwise similar policy issued on the standard basis that  
1220 provides higher uniform amounts of insurance, adjusted premiums  
1221 and present values for such substandard policy may be calculated as if  
1222 it were issued to provide such higher uniform amounts of insurance on  
1223 the standard basis; (8) all adjusted premiums and present values  
1224 referred to in this section shall be calculated: (A) (i) For all policies of  
1225 ordinary insurance on the basis of the Commissioners' 1980 Standard  
1226 Ordinary Mortality Table or at the election of the company, for any one  
1227 or more specified plans of life insurance, on the basis of the  
1228 Commissioners' 1980 Standard Ordinary Mortality Table with ten-year  
1229 select mortality factors, or (ii) on or after January 1, 2005, until January  
1230 1, 2009, at the election of the company for any one or more specified  
1231 plans of life insurance issued on or after January 1, 2004, on the basis of  
1232 the Commissioners' 2001 Standard Ordinary Mortality Table, except  
1233 that with respect to such plans issued before April 1, 2005, such  
1234 mortality table shall be used solely for the basis of valuation and  
1235 nonforfeiture and shall not be used to increase the previously agreed  
1236 required premium, or (iii) for all policies issued on or after January 1,  
1237 2009, and prior to the operative date of the Valuation Manual, as set  
1238 forth in section 38a-78a, on the basis of the Commissioners' 2001  
1239 Standard Ordinary Mortality Table, or (iv) for all policies issued on or  
1240 after the operative date of the Valuation Manual, as set forth in section  
1241 38a-78a, on the basis of the Commissioners' Standard Mortality Table,  
1242 as defined in the Valuation Manual, to determine nonforfeiture values;  
1243 (B) for all policies of industrial insurance issued (i) prior to the  
1244 operative date of the Valuation Manual, as set forth in section 38a-78a,  
1245 on the basis of the Commissioners' 1961 Standard Industrial Mortality  
1246 Table, or (ii) on or after the operative date of the Valuation Manual, as  
1247 set forth in section 38a-78a, on the basis of the Commissioners'  
1248 Standard Mortality Table, as defined in the Valuation Manual, to  
1249 determine nonforfeiture values. As used in this subdivision and  
1250 subdivision (9) of this subsection, "Valuation Manual" has the same  
1251 meaning as provided in subsection (a) of section 38a-78; (C) for all  
1252 policies issued in a particular calendar year, on the basis of a rate of  
1253 interest not exceeding the nonforfeiture interest rate as defined in this

1254 subsection, for policies issued in that calendar year, provided: [, that:]  
1255 (i) At the option of the company, calculations for all policies issued in a  
1256 particular calendar year may be made on the basis of a rate of interest  
1257 not exceeding the nonforfeiture interest rate, as defined in this  
1258 subsection, for policies issued in the immediately preceding calendar  
1259 year; (ii) under any paid-up nonforfeiture benefit, including any paid-  
1260 up dividend additions, any cash surrender value available, whether or  
1261 not required by subsection (a) of this section, shall be calculated on the  
1262 basis of the mortality table and rate of interest used in determining the  
1263 amount of such paid-up nonforfeiture benefit and paid-up dividend  
1264 additions, if any; (iii) a company may calculate the amount of any  
1265 guaranteed paid-up nonforfeiture benefit including any paid-up  
1266 additions under the policy on the basis of an interest rate no lower  
1267 than that specified in the policy for calculating cash surrender values;  
1268 (iv) in calculating the present value of any paid-up term insurance  
1269 with accompanying pure endowment, if any, offered as a nonforfeiture  
1270 benefit, the rates of mortality assumed may be not more than those  
1271 shown in the Commissioners' 1980 Extended Term Insurance Table for  
1272 policies of ordinary insurance and not more than the Commissioners'  
1273 1961 Industrial Extended Term Insurance Table for policies of  
1274 industrial insurance; (v) for insurance issued on a substandard basis,  
1275 the calculation of any such adjusted premiums and present values may  
1276 be based on appropriate modifications of the aforementioned tables;  
1277 (vi) any ordinary mortality tables, adopted after 1980 by the National  
1278 Association of Insurance Commissioners that are approved by  
1279 regulations adopted by the commissioner, in accordance with the  
1280 provisions of chapter 54, for use in determining the minimum  
1281 nonforfeiture standard may be substituted for the Commissioners'  
1282 1980 Standard Ordinary Mortality Table with or without ten-year  
1283 select mortality factors or the Commissioners' 1980 Extended Term  
1284 Insurance Table; (vii) any industrial mortality tables, adopted after  
1285 1980 by the National Association of Insurance Commissioners that are  
1286 approved by regulations adopted by the commissioner, in accordance  
1287 with the provisions of chapter 54, for use in determining the minimum  
1288 nonforfeiture standard may be substituted for the Commissioners'

1289 1961 Standard Industrial Mortality Table or the Commissioners' 1961  
1290 Industrial Extended Term Insurance Table; (9) the nonforfeiture  
1291 interest rate per annum for any policy issued in a particular calendar  
1292 year shall be, (A) for policies issued prior to the operative date of the  
1293 Valuation Manual, as set forth in section 38a-78a, equal to one hundred  
1294 twenty-five per cent of the calendar year statutory valuation interest  
1295 rate for such policy as defined in the standard valuation law, rounded  
1296 to the nearest one quarter of one per cent, except that for policies  
1297 issued on or after January 1, 2016, such interest rate shall not be less  
1298 than four per cent if the Valuation Manual is not operative as of said  
1299 date, and (B) for policies issued on or after the operative date of the  
1300 Valuation Manual, as set forth in section 38a-78a, as defined in the  
1301 Valuation Manual; (10) notwithstanding any provision of the general  
1302 statutes, any refiling of nonforfeiture values or their methods of  
1303 computation for any previously approved policy form that involves  
1304 only a change in the interest rate or mortality table used to compute  
1305 nonforfeiture values shall not require refiling of any other provisions  
1306 of such policy form; (11) on or after October 1, 1981, but prior to  
1307 January 1, 1989, any company may file with the commissioner a  
1308 written notice of its election to comply with the provisions of this  
1309 subsection on or after a specified date and the provisions of this  
1310 subsection shall apply to such company on or after such specified date,  
1311 except that on or after January 1, 2005, but prior to January 1, 2009, any  
1312 company may file with the commissioner a written notice of its  
1313 election to comply with the provisions of this subsection on or after a  
1314 specified date with respect to the Commissioners' 2001 Standard  
1315 Ordinary Mortality Table and the provisions of this subsection shall  
1316 apply to such company. The provisions of this subsection shall apply  
1317 to policies issued by any company on or after January 1, 1989, except  
1318 that the provisions of this subsection with respect to the  
1319 Commissioners' 2001 Standard Ordinary Mortality Table shall apply to  
1320 policies issued by any company on or after January 1, 2009, unless  
1321 otherwise specified.

1322 Sec. 34. Subsection (a) of section 38a-440 of the general statutes is  
1323 repealed and the following is substituted in lieu thereof (*Effective*



1324     October 1, 2017):

1325         (a) This section shall not apply to any reinsurance, group annuity  
1326     purchased under a retirement plan or plan of deferred compensation  
1327     established or maintained by an employer, including a partnership or  
1328     sole proprietorship, or by an employee organization, or by both, other  
1329     than a plan providing individual retirement accounts or individual  
1330     retirement annuities under Section 408 of the Internal Revenue Code [,  
1331     as now or hereafter amended] of 1986, or any subsequent  
1332     corresponding internal revenue code of the United States, as amended  
1333     from time to time, premium deposit fund, variable annuity, investment  
1334     annuity, immediate annuity, any deferred annuity contract after  
1335     annuity payments have commenced, or reversionary annuity, nor to  
1336     any contract [which shall be] that is delivered outside this state  
1337     through an agent or other representative of the company issuing the  
1338     contract.

1339         Sec. 35. Subsection (a) of section 38a-465p of the general statutes is  
1340     repealed and the following is substituted in lieu thereof (*Effective*  
1341     *October 1, 2017*):

1342         (a) Any provider or broker lawfully transacting business in this state  
1343     prior to October 1, 2008, may continue to do so pending approval or  
1344     disapproval of such provider's or broker's application for a license,  
1345     provided such application is filed with the commissioner not later than  
1346     thirty days after October 1, 2008. During the time that such application  
1347     is pending with the commissioner, the applicant may use any form of  
1348     life settlement contract that has been filed with the commissioner  
1349     pending approval thereof, provided [that] such form is otherwise in  
1350     compliance with the provisions of this part. Any person transacting  
1351     business in this state under this provision shall be obligated to comply  
1352     with all other requirements of this part.

1353         Sec. 36. Subsection (a) of section 38a-472 of the general statutes is  
1354     repealed and the following is substituted in lieu thereof (*Effective*  
1355     *October 1, 2017*):

1356 (a) Whenever a contract by a third party agency provides for  
1357 payment to a beneficiary under the contract on account of bills  
1358 incurred by [him] such beneficiary for medical, surgical or hospital  
1359 care received by [him] such beneficiary, the assignment of the benefits  
1360 of the contract by [that] such beneficiary to the department head, as  
1361 defined in section 4-5, of a state agency, or any doctor or hospital  
1362 rendering such care, when sent by registered or certified mail to the  
1363 third party agency, with a copy to the insured, shall be authority for  
1364 the payment directly by the third party agency to the assignee. The  
1365 state shall have a lien, in an amount equal to the care rendered, on the  
1366 proceeds of such contracts for care rendered by any state hospital,  
1367 institution or other facility, written notice of which shall be authority  
1368 for the payment directly by the third party agency to the state.

1369 Sec. 37. Subsection (a) of section 38a-472g of the general statutes is  
1370 repealed and the following is substituted in lieu thereof (*Effective*  
1371 *October 1, 2017*):

1372 (a) (1) No insurer, health care center, fraternal benefit society,  
1373 hospital service corporation or medical service corporation or other  
1374 entity, delivering, issuing for delivery, renewing, amending or  
1375 continuing an individual or group health insurance policy in this state  
1376 providing coverage of the type specified in subdivisions (1), (2), (4),  
1377 (11) and (12) of section 38a-469 or utilization review company  
1378 performing utilization review for such insurer, center, society,  
1379 corporation or entity, that [preauthorizes] issues prior authorization  
1380 for or precertifies, on or after January 1, 2012, an admission, service,  
1381 procedure or extension of stay shall reverse or rescind such  
1382 [preauthorization] prior authorization or precertification or refuse to  
1383 pay for such admission, service, procedure or extension of stay if:

1384 (A) Such insurer, center, society, corporation, entity or company  
1385 failed to notify the insured's or enrollee's health care provider at least  
1386 three business days prior to the scheduled date of such admission,  
1387 service, procedure or extension of stay that such [preauthorization]  
1388 prior authorization or precertification has been reversed or rescinded

1389 on the basis of medical necessity, fraud or lack of coverage; and

1390 (B) Such admission, service, procedure or extension of stay has  
1391 taken place in reliance on such [preauthorization] prior authorization  
1392 or precertification.

1393 (2) The provisions of this subsection shall apply regardless of  
1394 whether such [preauthorization] prior authorization or precertification  
1395 is required or is requested by an insured's or enrollee's health care  
1396 provider. Unless reversed or rescinded as set forth in subparagraph  
1397 (A) of subdivision (1) of this subsection, such [preauthorization] prior  
1398 authorization or precertification shall be effective for not less than sixty  
1399 days from the date of issuance.

1400 Sec. 38. Section 38a-473 of the general statutes is repealed and the  
1401 following is substituted in lieu thereof (*Effective October 1, 2017*):

1402 (a) No insurance company, fraternal benefit society, hospital service  
1403 corporation, medical service corporation, health care center or other  
1404 entity [which] that delivers or issues for delivery Medicare supplement  
1405 insurance policies or certificates, written, delivered, continued or  
1406 renewed in this state during the previous calendar year shall  
1407 incorporate in its rates for Medicare supplement insurance calculated  
1408 in accordance with sections 38a-495, 38a-495a, as amended by this act,  
1409 and 38a-522, as amended by this act, and any regulations adopted  
1410 pursuant to said sections, factors for expenses [which] that exceed one  
1411 hundred fifty per cent of the average expense ratio for the entire  
1412 written premium for all lines of health insurance of such company,  
1413 society, corporation, center or other entity for the previous calendar  
1414 year.

1415 (b) No insurance company, fraternal benefit society, hospital service  
1416 corporation, medical service corporation, health care center or other  
1417 entity [which] that delivers or issues for delivery in this state any  
1418 Medicare supplement policies or certificates shall incorporate in its  
1419 rates or determinations to grant coverage for Medicare supplement  
1420 insurance policies or certificates any factors or values based on the age,

1421 gender, previous claims history or the medical condition of any person  
1422 covered by such policy or certificate.

1423 Sec. 39. Section 38a-474 of the general statutes is repealed and the  
1424 following is substituted in lieu thereof (*Effective October 1, 2017*):

1425 (a) Any insurance company, fraternal benefit society, hospital  
1426 service corporation, medical service corporation, health care center or  
1427 other entity [which] that delivers, issues for delivery, renews, amends  
1428 or continues in this state any Medicare supplement policy or  
1429 certificate, as defined in sections 38a-495, 38a-495a, as amended by this  
1430 act, and 38a-522, as amended by this act, seeking to change its rates  
1431 shall file a request for such change with the Insurance Department at  
1432 least sixty days prior to the proposed effective date of such change.  
1433 The Insurance Department shall review the request and, with respect  
1434 to requests for an increase in rates, shall hold a public hearing on such  
1435 increase. The Insurance Commissioner shall approve or deny the  
1436 request not later than forty-five days after its receipt. The Insurance  
1437 Commissioner shall adopt regulations, in accordance with chapter 54,  
1438 to set requirements for the submission of data pertaining to a request  
1439 to change rates and to define the policies utilized in making a decision  
1440 on such change in rates.

1441 (b) No insurance company, fraternal benefit society, hospital service  
1442 corporation, medical service corporation, health care center or other  
1443 entity [which] that delivers or issues for delivery in this state any  
1444 Medicare supplement policies or certificates shall incorporate in its  
1445 rates or determinations to grant coverage for Medicare supplement  
1446 insurance policies or certificates any factors or values based on the age,  
1447 gender, previous claims history or the medical condition of the person  
1448 covered by such policy or certificate.

1449 Sec. 40. Section 38a-475 of the general statutes is repealed and the  
1450 following is substituted in lieu thereof (*Effective October 1, 2017*):

1451 The Insurance Department shall only precertify long-term care  
1452 insurance policies [which] that (1) alert the purchaser to the availability

1453 of consumer information and public education provided by the  
1454 Department on Aging pursuant to section 17b-251; (2) offer the option  
1455 of home and community-based services in addition to nursing home  
1456 care; (3) in all home care plans, include case management services  
1457 delivered by an access agency approved by the Office of Policy and  
1458 Management and the Department of Social Services as meeting the  
1459 requirements for such agency as defined in regulations adopted  
1460 pursuant to subsection (e) of section 17b-342, which services shall  
1461 include, but need not be limited to, the development of a  
1462 comprehensive individualized assessment and care plan and, as  
1463 needed, the coordination of appropriate services and the monitoring of  
1464 the delivery of such services; (4) provide inflation protection; (5)  
1465 provide for the keeping of records and an explanation of benefit  
1466 reports on insurance payments which count toward Medicaid resource  
1467 exclusion; and (6) provide the management information and reports  
1468 necessary to document the extent of Medicaid resource protection  
1469 offered and to evaluate the Connecticut Partnership for Long-Term  
1470 Care. No policy shall be precertified if it requires prior hospitalization  
1471 or a prior stay in a nursing home as a condition of providing benefits.  
1472 The commissioner may adopt regulations, in accordance with chapter  
1473 54, to carry out the precertification provisions of this section.

1474 Sec. 41. Subdivision (1) of subsection (a) of section 38a-476 of the  
1475 general statutes is repealed and the following is substituted in lieu  
1476 thereof (*Effective October 1, 2017*):

1477 (1) "Health insurance plan" means any hospital and medical expense  
1478 incurred policy, hospital or medical service plan contract and health  
1479 care center subscriber contract. "Health insurance plan" does not  
1480 include (A) short-term health insurance issued on a nonrenewable  
1481 basis with a duration of six months or less, accident only, credit,  
1482 dental, vision, Medicare supplement, long-term care or disability  
1483 insurance, hospital indemnity coverage, coverage issued as a  
1484 supplement to liability insurance, insurance arising out of a workers'  
1485 compensation or similar law, automobile medical payments insurance,  
1486 or insurance under which beneficiaries are payable without regard to

1487 fault and which is statutorily required to be contained in any liability  
1488 insurance policy or equivalent self-insurance, or (B) policies of  
1489 specified disease or limited benefit health insurance, provided [that]  
1490 the carrier offering such policies files on or before March first of each  
1491 year a certification with the Insurance Commissioner that contains the  
1492 following: (i) A statement from the carrier certifying that such policies  
1493 are being offered and marketed as supplemental health insurance and  
1494 not as a substitute for hospital or medical expense insurance; (ii) a  
1495 summary description of each such policy including the average annual  
1496 premium rates, or range of premium rates in cases where premiums  
1497 vary by age, gender or other factors, charged for such policies in the  
1498 state; and (iii) in the case of a policy that is described in this  
1499 subparagraph and that is offered for the first time in this state on or  
1500 after October 1, 1993, the carrier files with the commissioner the  
1501 information and statement required in this subparagraph at least thirty  
1502 days prior to the date such policy is issued or delivered in this state.

1503 Sec. 42. Section 38a-476a of the general statutes is repealed and the  
1504 following is substituted in lieu thereof (*Effective October 1, 2017*):

1505 (a) Each insurance company, fraternal benefit society, hospital  
1506 service corporation, medical service corporation and health care center  
1507 shall comply with sections 2742, 2743, and 2747 of the Public Health  
1508 Service Act, as set forth in the Health Insurance Portability and  
1509 Accountability Act of 1996 (P.L. 104-191), [(HIPAA)], as amended from  
1510 time to time, concerning guaranteed renewability of individual health  
1511 insurance coverage and certification of coverage.

1512 (b) Each insurance company, fraternal benefit society, hospital  
1513 service corporation, medical service corporation and health care center  
1514 shall comply with sections 2702, 2704, 2705 and 2712 of the Public  
1515 Health Service Act, as set forth in the Health Insurance Portability and  
1516 Accountability Act of 1996 (P.L. 104-191 and 104-204), [(HIPAA)], as  
1517 amended from time to time, concerning discrimination based on health  
1518 status, newborns' and mothers' health, parity of mental health benefits  
1519 and guaranteed renewability of coverage for employers in the group

1520 market, with respect to health insurance coverage offered in the small  
1521 and large group markets as defined in said Public Health Service Act.

1522 (c) Each insurance company, fraternal benefit society, hospital  
1523 service corporation, medical service corporation and health care center  
1524 shall comply with sections 2711 and 2713 of the Public Health Service  
1525 Act, as set forth in the Health Insurance Portability and Accountability  
1526 Act of 1996 (P.L. 104-191), [(HIPAA)], as amended from time to time,  
1527 concerning guaranteed availability and disclosure of information for  
1528 employers with respect to health insurance coverage offered in the  
1529 small group market as defined in said Public Health Service Act.

1530 (d) No provision of the general statutes concerning a [HIPAA]  
1531 requirement in the Health Insurance Portability and Accountability  
1532 Act of 1996 (P.L. 104-191), as amended from time to time, shall be  
1533 construed to supersede any other provision of the general statutes  
1534 except to the extent that such other provision prevents the application  
1535 of a requirement of [HIPAA] said act.

1536 (e) This section shall apply to insurance companies, fraternal benefit  
1537 societies, hospital service corporations, medical service corporations  
1538 and health care centers on and after the dates specified in the Public  
1539 Health Service Act, as set forth in the Health Insurance Portability and  
1540 Accountability Act of 1996, (P.L. 104-191 and 104-204), [(HIPAA)], as  
1541 amended from time to time.

1542 (f) The commissioner may adopt regulations, in accordance with the  
1543 provisions of chapter 54, to implement the provisions of this section  
1544 and the provisions of the Public Health Service Act, as set forth in the  
1545 Health Insurance Portability and Accountability Act of 1996, as  
1546 amended from time to time.

1547 Sec. 43. Subdivision (2) of subsection (a) of section 38a-477d of the  
1548 general statutes is repealed and the following is substituted in lieu  
1549 thereof (*Effective October 1, 2017*):

1550 (2) Make available to consumers a way to determine accurately (A)

1551 whether a specific prescription drug is available under such policy's  
1552 drug formulary; (B) the coinsurance, copayment, deductible or other  
1553 out-of-pocket expense applicable to such drug; (C) whether such drug  
1554 is covered when dispensed by a physician or a clinic; (D) whether such  
1555 drug requires [preauthorization] prior authorization or the use of step  
1556 therapy; (E) whether specific types of health care specialists are in-  
1557 network; and (F) whether a specific health care provider or hospital is  
1558 in-network.

1559 Sec. 44. Subsection (c) of section 38a-477d of the general statutes is  
1560 repealed and the following is substituted in lieu thereof (*Effective*  
1561 *October 1, 2017*):

1562 (c) The Insurance Commissioner shall post links on [its] the  
1563 Insurance Department's Internet web site to any on-line tools or  
1564 calculators to help consumers compare and evaluate health insurance  
1565 policies and plans.

1566 Sec. 45. Subsection (a) of section 38a-477e of the general statutes is  
1567 repealed and the following is substituted in lieu thereof (*Effective*  
1568 *October 1, 2017*):

1569 (a) On and after January 1, 2017, each health carrier, as defined in  
1570 section 38a-1084a, shall maintain an Internet web site and toll-free  
1571 telephone number that enables consumers to request and obtain: (1)  
1572 Information on in-network costs for inpatient admissions, health care  
1573 procedures and services, including (A) the allowed amount for, at a  
1574 minimum, admissions and procedures reported to the exchange  
1575 pursuant to section 38a-1084a for each health care provider in the state;  
1576 (B) the estimated out-of-pocket costs that a consumer would be  
1577 responsible for paying for any such admission or procedure that is  
1578 medically necessary, including any facility fee, coinsurance,  
1579 copayment, deductible or other out-of-pocket expense; and (C) data or  
1580 other information concerning (i) quality measures for the health care  
1581 provider, (ii) patient satisfaction, to the extent such information is  
1582 available, (iii) a directory of participating providers, as defined in  
1583 section 38a-472f, in accordance with the provisions of section [38a-472f]



1584 38a-477h; and (2) information on out-of-network costs for inpatient  
1585 admissions, health care procedures and services.

1586 Sec. 46. Subdivision (8) of subsection (b) of section 38a-478g of the  
1587 general statutes is repealed and the following is substituted in lieu  
1588 thereof (*Effective October 1, 2017*):

1589 (8) [Preauthorization] Prior authorization and utilization review  
1590 requirements and procedures, internal grievance procedures and  
1591 internal and external complaint procedures;

1592 Sec. 47. Subdivision (8) of subsection (a) of section 38a-479qq of the  
1593 general statutes is repealed and the following is substituted in lieu  
1594 thereof (*Effective October 1, 2017*):

1595 (8) "Person" [means a person, as defined] has the same meaning as  
1596 provided in section 38a-1.

1597 Sec. 48. Subsection (a) of section 38a-482c of the general statutes is  
1598 repealed and the following is substituted in lieu thereof (*Effective*  
1599 *October 1, 2017*):

1600 (a) No individual health insurance policy providing coverage of the  
1601 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
1602 469 delivered, issued for delivery, amended, renewed or continued in  
1603 this state shall include a lifetime limit on the dollar value of benefits for  
1604 a covered individual, for covered benefits that are essential health  
1605 benefits, as defined in the Patient Protection and Affordable Care Act,  
1606 P.L. [111-1448] 111-148, as amended from time to time, or regulations  
1607 adopted thereunder.

1608 Sec. 49. Section 38a-483a of the general statutes is repealed and the  
1609 following is substituted in lieu thereof (*Effective October 1, 2017*):

1610 Notwithstanding the provisions of section 38a-476, as amended by  
1611 this act, the Insurance Commissioner may adopt regulations, in  
1612 accordance with the provisions of chapter 54, to allow exclusionary  
1613 riders to be issued for individual health insurance policies that are not

1614 subject to Section 2701 of the Public Health Service Act, as set forth in  
1615 the Health Insurance Portability and Accountability Act of 1996, [(P.L.  
1616 104-191) (HIPAA)] P.L. 104-191, as amended from time to time.

1617 Sec. 50. Subsection (a) of section 38a-489 of the general statutes is  
1618 repealed and the following is substituted in lieu thereof (*Effective*  
1619 *October 1, 2017*):

1620 (a) Each individual health insurance policy providing coverage of  
1621 the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of  
1622 section 38a-469, delivered, issued for delivery, renewed, amended or  
1623 continued in this state [more than one hundred twenty days after July  
1624 1, 1971,] that provides that coverage of a dependent child shall  
1625 terminate upon attainment of the limiting age for dependent children  
1626 specified in the policy shall also provide in substance that attainment  
1627 of the limiting age shall not operate to terminate the coverage of the  
1628 child if at such date the child is and continues thereafter to be both (1)  
1629 incapable of self-sustaining employment by reason of mental or  
1630 physical handicap, as certified by the child's physician or advanced  
1631 practice registered nurse on a form provided by the insurer, hospital  
1632 service corporation, medical service corporation or health care center,  
1633 and (2) chiefly dependent upon the policyholder or subscriber for  
1634 support and maintenance.

1635 Sec. 51. Section 38a-492d of the general statutes is repealed and the  
1636 following is substituted in lieu thereof (*Effective October 1, 2017*):

1637 (a) Each individual health insurance policy providing coverage of  
1638 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
1639 38a-469 delivered, issued for delivery or renewed in this state [on or  
1640 after October 1, 1997,] shall provide coverage for laboratory and  
1641 diagnostic tests for all types of diabetes.

1642 (b) Notwithstanding the provisions of section 38a-492a, each  
1643 individual health insurance policy providing coverage of the type  
1644 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
1645 delivered, issued for delivery or renewed in this state [on or after

1646 October 1, 1997,] shall provide medically necessary coverage for the  
1647 treatment of insulin-dependent diabetes, insulin-using diabetes,  
1648 gestational diabetes and non-insulin-using diabetes. Such coverage  
1649 shall include medically necessary equipment, in accordance with the  
1650 insured person's treatment plan, drugs and supplies prescribed by a  
1651 prescribing practitioner, as defined in section 20-571.

1652 Sec. 52. Subsection (a) of section 38a-492e of the general statutes is  
1653 repealed and the following is substituted in lieu thereof (*Effective*  
1654 *October 1, 2017*):

1655 (a) Each individual health insurance policy providing coverage of  
1656 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
1657 38a-469 delivered, issued for delivery, renewed or continued in this  
1658 state [on or after January 1, 2000,] shall provide coverage for outpatient  
1659 self-management training for the treatment of insulin-dependent  
1660 diabetes, insulin-using diabetes, gestational diabetes and non-insulin-  
1661 using diabetes if the training is prescribed by a licensed health care  
1662 professional who has appropriate state licensing authority to prescribe  
1663 such training. As used in this section, "outpatient self-management  
1664 training" includes, but is not limited to, education and medical  
1665 nutrition therapy. Diabetes self-management training shall be  
1666 provided by a certified, registered or licensed health care professional  
1667 trained in the care and management of diabetes and authorized to  
1668 provide such care within the scope of the professional's practice.

1669 Sec. 53. Section 38a-492m of the general statutes is repealed and the  
1670 following is substituted in lieu thereof (*Effective October 1, 2017*):

1671 Each individual health insurance policy providing coverage of the  
1672 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
1673 469 delivered, issued for delivery, amended, renewed or continued in  
1674 this state [on or after January 1, 2010,] that provides coverage for  
1675 prescription eye drops, shall not deny coverage for a renewal of  
1676 prescription eye drops when (1) the renewal is requested by the  
1677 insured less than thirty days from the later of (A) the date the original  
1678 prescription was distributed to the insured, or (B) the date the last

1679 renewal of such prescription was distributed to the insured, and (2) the  
1680 prescribing physician, prescribing advanced practice registered nurse  
1681 or prescribing optometrist indicates on the original prescription that  
1682 additional quantities are needed and the renewal requested by the  
1683 insured does not exceed the number of additional quantities needed.

1684 Sec. 54. Section 38a-493 of the general statutes is repealed and the  
1685 following is substituted in lieu thereof (*Effective October 1, 2017*):

1686 (a) Each individual health insurance policy providing coverage of  
1687 the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of  
1688 section 38a-469 delivered, issued for delivery, renewed, amended or  
1689 continued in this state shall provide coverage providing  
1690 reimbursement for home health care to residents in this state.

1691 (b) For the purposes of this section [, "hospital"] and section 38a-494:

1692 (1) "Hospital" means an institution that is primarily engaged in  
1693 providing, by or under the supervision of physicians, to inpatients [(1)]  
1694 (A) diagnostic, surgical and therapeutic services for medical diagnosis,  
1695 treatment and care of injured, disabled or sick persons, or [(2)] (B)  
1696 medical rehabilitation services for the rehabilitation of injured,  
1697 disabled or sick persons. [, provided "hospital" shall] "Hospital" does  
1698 not include a residential care home, nursing home, rest home or  
1699 alcohol or drug treatment facility, as defined in section 19a-490; [, For  
1700 the purposes of this section and section 38a-494, "home health care"]

1701 (2) "Home health care" means the continued care and treatment of a  
1702 covered person who is under the care of a physician or an advanced  
1703 practice registered nurse but only if (A) continued hospitalization  
1704 would otherwise have been required if home health care was not  
1705 provided, except in the case of a covered person diagnosed by a  
1706 physician or an advanced practice registered nurse as terminally ill  
1707 with a prognosis of six months or less to live, and (B) the plan covering  
1708 the home health care is established and approved in writing by such  
1709 physician or advanced practice registered nurse within seven days  
1710 following termination of a hospital confinement as a resident inpatient

1711 for the same or a related condition for which the covered person was  
1712 hospitalized, except that in the case of a covered person diagnosed by  
1713 a physician or an advanced practice registered nurse as terminally ill  
1714 with a prognosis of six months or less to live, such plan may be so  
1715 established and approved at any time irrespective of whether such  
1716 covered person was so confined or, if such covered person was so  
1717 confined, irrespective of such seven-day period, and (C) such home  
1718 health care is commenced within seven days following discharge,  
1719 except in the case of a covered person diagnosed by a physician or an  
1720 advanced practice registered nurse as terminally ill with a prognosis of  
1721 six months or less to live;

1722 (3) "Home health agency" means an agency or organization that  
1723 meets each of the following requirements: (A) It is primarily engaged  
1724 in and is federally certified as a home health agency and duly licensed,  
1725 if such licensing is required, by the appropriate licensing authority, to  
1726 provide nursing and other therapeutic services; (B) its policies are  
1727 established by a professional group associated with such agency or  
1728 organization, including at least one physician or advanced practice  
1729 registered nurse and at least one registered nurse, to govern the  
1730 services provided; (C) it provides for full-time supervision of such  
1731 services by a physician, an advanced practice registered nurse or a  
1732 registered nurse; (D) it maintains a complete medical record on each  
1733 patient; and (E) it has an administrator; and

1734 (4) "Medical social services" means services rendered, under the  
1735 direction of a physician or an advanced practice registered nurse, by a  
1736 qualified social worker holding a master's degree from an accredited  
1737 school of social work, including, but not limited to, (A) assessment of  
1738 the social, psychological and family problems related to or arising out  
1739 of such covered person's illness and treatment, (B) appropriate action  
1740 and utilization of community resources to assist in resolving such  
1741 problems, and (C) participation in the development of the overall plan  
1742 of treatment for such covered person.

1743 (c) Home health care shall be provided by a home health agency.

1744 [The term "home health agency" means an agency or organization that  
1745 meets each of the following requirements: (1) It is primarily engaged in  
1746 and is federally certified as a home health agency and duly licensed, if  
1747 such licensing is required, by the appropriate licensing authority, to  
1748 provide nursing and other therapeutic services, (2) its policies are  
1749 established by a professional group associated with such agency or  
1750 organization, including at least one physician or advanced practice  
1751 registered nurse and at least one registered nurse, to govern the  
1752 services provided, (3) it provides for full-time supervision of such  
1753 services by a physician, an advanced practice registered nurse or a  
1754 registered nurse, (4) it maintains a complete medical record on each  
1755 patient, and (5) it has an administrator.]

1756 (d) Home health care shall consist of, but shall not be limited to, the  
1757 following: (1) Part-time or intermittent nursing care by a registered  
1758 nurse or by a licensed practical nurse under the supervision of a  
1759 registered nurse, if the services of a registered nurse are not available;  
1760 (2) part-time or intermittent home health aide services, consisting  
1761 primarily of patient care of a medical or therapeutic nature by other  
1762 than a registered or licensed practical nurse; (3) physical, occupational  
1763 or speech therapy; (4) medical supplies, drugs and medicines  
1764 prescribed by a physician, advanced practice registered nurse or  
1765 physician assistant and laboratory services to the extent such charges  
1766 would have been covered under the policy or contract if the covered  
1767 person had remained or had been confined in the hospital; (5) medical  
1768 social services [, as hereinafter defined,] provided to or for the benefit  
1769 of a covered person diagnosed by a physician or an advanced practice  
1770 registered nurse as terminally ill with a prognosis of six months or less  
1771 to live. [Medical social services are defined to mean services rendered,  
1772 under the direction of a physician or an advanced practice registered  
1773 nurse by a qualified social worker holding a master's degree from an  
1774 accredited school of social work, including but not limited to (A)  
1775 assessment of the social, psychological and family problems related to  
1776 or arising out of such covered person's illness and treatment; (B)  
1777 appropriate action and utilization of community resources to assist in  
1778 resolving such problems; (C) participation in the development of the

1779 overall plan of treatment for such covered person.]

1780 (e) The policy may contain a limitation on the number of home  
1781 health care visits for which benefits are payable, but the number of  
1782 such visits shall not be less than eighty in any calendar year or in any  
1783 continuous period of twelve months for each person covered under a  
1784 policy or contract, except in the case of a covered person diagnosed by  
1785 a physician or an advanced practice registered nurse as terminally ill  
1786 with a prognosis of six months or less to live, the yearly benefit for  
1787 medical social services shall not exceed two hundred dollars. Each visit  
1788 by a representative of a home health agency shall be considered as one  
1789 home health care visit [;] and four hours of home health aide service  
1790 shall be considered as one home health care visit.

1791 (f) Home health care benefits may be subject to an annual deductible  
1792 of not more than fifty dollars for each person covered under a policy  
1793 and may be subject to a coinsurance provision that provides for  
1794 coverage of not less than seventy-five per cent of the reasonable  
1795 charges for such services. Such policy may also contain reasonable  
1796 limitations and exclusions applicable to home health care coverage. A  
1797 ["high deductible health plan"] high deductible plan, as defined in  
1798 Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of  
1799 1986, or any subsequent corresponding internal revenue code of the  
1800 United States, as amended from time to time, [amended,] used to  
1801 establish a ["medical savings account" or "Archer MSA"] medical  
1802 savings account or an Archer MSA pursuant to Section 220 of said  
1803 Internal Revenue Code or a ["health savings account"] health savings  
1804 account pursuant to Section 223 of said Internal Revenue Code shall  
1805 not be subject to the deductible limits set forth in this subsection.

1806 (g) No policy, except any major medical expense policy as described  
1807 in subsection (j) of this section, shall be required to provide home  
1808 health care coverage to persons eligible for Medicare.

1809 (h) No insurer, hospital service corporation or health care center  
1810 shall be required to provide benefits beyond the maximum amount  
1811 limits contained in its policy.

1812 (i) If a person is eligible for home health care coverage under more  
1813 than one policy, the home health care benefits shall only be provided  
1814 by that policy that would have provided the greatest benefits for  
1815 hospitalization if the person had remained or had been hospitalized.

1816 (j) Each individual major medical expense policy delivered, issued  
1817 for delivery, renewed, amended or continued in this state shall provide  
1818 coverage in accordance with the provisions of this section for home  
1819 health care to residents in this state whose benefits are no longer  
1820 provided under Medicare or any applicable individual health  
1821 insurance policy.

1822 Sec. 55. Subsection (a) of section 38a-499a of the general statutes is  
1823 repealed and the following is substituted in lieu thereof (*Effective*  
1824 *October 1, 2017*):

1825 (a) As used in this section, "telehealth" has the same meaning as  
1826 provided in section 19a-906.

1827 Sec. 56. Subsections (a) and (b) of section 38a-501 of the general  
1828 statutes are repealed and the following is substituted in lieu thereof  
1829 (*Effective October 1, 2017*):

1830 (a) (1) As used in this section, "long-term care policy" means any  
1831 individual health insurance policy delivered or issued for delivery to  
1832 any resident of this state on or after July 1, 1986, that is designed to  
1833 provide, within the terms and conditions of the policy, benefits on an  
1834 expense-incurred, indemnity or prepaid basis for necessary care or  
1835 treatment of an injury, illness or loss of functional capacity provided  
1836 by a certified or licensed health care provider in a setting other than an  
1837 acute care hospital, for at least one year after an elimination period (A)  
1838 not to exceed one hundred days of confinement, or (B) of over one  
1839 hundred days but not to exceed two years of confinement, provided  
1840 such period is covered by an irrevocable trust in an amount estimated  
1841 to be sufficient to furnish coverage to the grantor of the trust for the  
1842 duration of the elimination period. Such trust shall create an  
1843 unconditional duty to pay the full amount held in trust exclusively to



1844 cover the costs of confinement during the elimination period, subject  
1845 only to taxes and any trustee's charges allowed by law. Payment shall  
1846 be made directly to the provider. The duty of the trustee may be  
1847 enforced by the state, the grantor or any person acting on behalf of the  
1848 grantor. A long-term care policy shall provide benefits for confinement  
1849 in a nursing home or confinement in the insured's own home or both.  
1850 Any additional benefits provided shall be related to long-term  
1851 treatment of an injury, illness or loss of functional capacity. "Long-term  
1852 care policy" [shall] does not include any such policy that is offered  
1853 primarily to provide basic Medicare supplement coverage, basic  
1854 medical-surgical expense coverage, hospital confinement indemnity  
1855 coverage, major medical expense coverage, disability income  
1856 protection coverage, accident only coverage, specified accident  
1857 coverage or limited benefit health coverage.

1858 (2) (A) No insurance company, fraternal benefit society, hospital  
1859 service corporation, medical service corporation or health care center  
1860 delivering, issuing for delivery, renewing, continuing or amending any  
1861 long-term care policy in this state may refuse to accept, or refuse to  
1862 make reimbursement pursuant to, a claim for benefits submitted by or  
1863 prepared with the assistance of a managed residential community, as  
1864 defined in section 19a-693, in accordance with subdivision (7) of  
1865 subsection (a) of section 19a-694, solely because such claim for benefits  
1866 was submitted by or prepared with the assistance of a managed  
1867 residential community.

1868 (B) Each insurance company, fraternal benefit society, hospital  
1869 service corporation, medical service corporation or health care center  
1870 delivering, issuing for delivery, renewing, continuing or amending any  
1871 long-term care policy in this state shall, upon receipt of a written  
1872 authorization executed by the insured, (i) disclose information to a  
1873 managed residential community for the purpose of determining such  
1874 insured's eligibility for an insurance benefit or payment, and (ii)  
1875 provide a copy of the initial acceptance or declination of a claim for  
1876 benefits to the managed residential community at the same time such  
1877 acceptance or declination is made to the insured.

1878 (b) (1) No insurance company, fraternal benefit society, hospital  
1879 service corporation, medical service corporation or health care center  
1880 may deliver or issue for delivery any long-term care policy that has a  
1881 loss ratio of less than sixty per cent for any individual long-term care  
1882 policy. An issuer shall not use or change premium rates for a long-  
1883 term care policy unless the rates have been filed with and approved by  
1884 the Insurance Commissioner. Any rate filings or rate revisions shall  
1885 demonstrate that anticipated claims in relation to premiums when  
1886 combined with actual experience to date can be expected to comply  
1887 with the loss ratio requirement of this section. A rate filing shall  
1888 include the factors and methodology used to estimate irrevocable trust  
1889 values if the policy includes an option for the elimination period  
1890 specified in subdivision (1) of subsection (a) of this section.

1891 (2) (A) Any insurance company, fraternal benefit society, [health]  
1892 hospital service corporation, medical service corporation or health care  
1893 center that files a rate filing for an increase in premium rates for a long-  
1894 term care policy that is for twenty per cent or more shall spread the  
1895 increase over a period of not less than three years. Such company,  
1896 society, corporation or center shall use a periodic rate increase that is  
1897 actuarially equivalent to a single rate increase and a current interest  
1898 rate for the period chosen.

1899 (B) Prior to implementing a premium rate increase, each such  
1900 company, society, corporation or center shall:

1901 (i) Notify its policyholders of such premium rate increase and make  
1902 available to such policyholders the additional choice of reducing the  
1903 policy benefits to reduce the premium rate. Such notice shall include a  
1904 description of such policy benefit reductions. The premium rates for  
1905 any benefit reductions shall be based on the new premium rate  
1906 schedule;

1907 (ii) Provide policyholders not less than thirty calendar days to elect  
1908 a reduction in policy benefits; and

1909 (iii) Include a statement in such notice that if a policyholder fails to

1910 elect a reduction in policy benefits by the end of the notice period and  
1911 has not cancelled the policy, the policyholder will be deemed to have  
1912 elected to retain the existing policy benefits.

1913 Sec. 57. Subsection (a) of section 38a-503a of the general statutes is  
1914 repealed and the following is substituted in lieu thereof (*Effective*  
1915 *October 1, 2017*):

1916 (a) No individual health insurance plan [, as defined in subdivision  
1917 (1) of subsection (a) of section 38a-476,] or insurance arrangement, as  
1918 both terms are defined in [subdivision (2) of subsection (a) of] section  
1919 38a-476, as amended by this act, may refuse to cover an individual  
1920 health insurance applicant due to breast cancer if such applicant has  
1921 remained free from breast cancer for at least five years prior to the  
1922 applicant's request for individual health insurance coverage. The  
1923 individual health insurance carrier may require that the applicant  
1924 submit to a physical examination.

1925 Sec. 58. Subdivisions (2) to (5), inclusive, of section 38a-505 of the  
1926 general statutes are repealed and the following is substituted in lieu  
1927 thereof (*Effective October 1, 2017*):

1928 (2) The commissioner shall adopt regulations, in accordance with  
1929 the provisions of chapter 54, that specify prohibited policy provisions  
1930 not otherwise specifically authorized by statute that in the opinion of  
1931 the commissioner are unjust, unfair or unfairly discriminatory to the  
1932 policyholder, any person insured under the policy or any beneficiary.

1933 (3) The commissioner shall adopt regulations, in accordance with  
1934 the provisions of chapter 54, to establish minimum standards for  
1935 benefits under each of the following categories of coverage in  
1936 individual policies: Basic hospital expense coverage, basic medical-  
1937 surgical expense coverage, hospital confinement indemnity coverage,  
1938 major medical expense coverage, disability income protection  
1939 coverage, accident only coverage, specified accident coverage and  
1940 specified disease coverage.

1941 (4) Nothing in this section shall preclude the issuance of any policy  
1942 that combines two or more of the categories of coverage enumerated in  
1943 subdivision (3) of this section, except that specified accident coverage  
1944 shall not be combined with any other category of coverage. The  
1945 commissioner shall prescribe the method of identification of policies  
1946 based upon coverage provided.

1947 (5) No policy shall be delivered or issued for delivery in this state  
1948 that does not meet the prescribed minimum standards for the  
1949 categories of coverage listed in subdivision (3) of this section, provided  
1950 nothing in this section shall preclude the [issuance or] delivery or  
1951 issuance of any policy that does not meet such prescribed minimum  
1952 standards of coverage so long as such policy is clearly identified as not  
1953 meeting such prescribed standards.

1954 Sec. 59. Subsection (a) of section 38a-512c of the general statutes is  
1955 repealed and the following is substituted in lieu thereof (*Effective*  
1956 *October 1, 2017*):

1957 (a) No group health insurance policy providing coverage of the type  
1958 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
1959 delivered, issued for delivery, amended, renewed or continued in this  
1960 state shall include a lifetime limit on the dollar value of benefits for a  
1961 covered individual, for covered benefits that are essential health  
1962 benefits, as defined in the Patient Protection and Affordable Care Act,  
1963 P.L. [111-1448] 111-148, as amended from time to time, or regulations  
1964 adopted thereunder.

1965 Sec. 60. Subsection (a) of section 38a-515 of the general statutes is  
1966 repealed and the following is substituted in lieu thereof (*Effective*  
1967 *October 1, 2017*):

1968 (a) Each group health insurance policy providing coverage of the  
1969 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section  
1970 38a-469 delivered, issued for delivery, renewed, amended or continued  
1971 in this state [more than one hundred twenty days after July 1, 1971,]  
1972 that provides that coverage of a dependent child of an employee or

1973 other member of the covered group shall terminate upon attainment of  
1974 the limiting age for dependent children specified in the policy shall  
1975 also provide in substance that attainment of the limiting age shall not  
1976 operate to terminate the coverage of the child if at such date the child  
1977 is and continues thereafter to be both (1) incapable of self-sustaining  
1978 employment by reason of mental or physical handicap, as certified by  
1979 the child's physician or advanced practice registered nurse on a form  
1980 provided by the insurer, hospital service corporation, medical service  
1981 corporation or health care center, and (2) chiefly dependent upon such  
1982 employee or member for support and maintenance.

1983 Sec. 61. Section 38a-518d of the general statutes is repealed and the  
1984 following is substituted in lieu thereof (*Effective October 1, 2017*):

1985 (a) Each group health insurance policy providing coverage of the  
1986 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
1987 469 delivered, issued for delivery or renewed in this state [on or after  
1988 October 1, 1997,] shall provide coverage for laboratory and diagnostic  
1989 tests for all types of diabetes.

1990 (b) Notwithstanding the provisions of section 38a-518a, each group  
1991 health insurance policy providing coverage of the type specified in  
1992 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,  
1993 issued for delivery or renewed in this state [on or after October 1,  
1994 1997,] shall provide medically necessary coverage for the treatment of  
1995 insulin-dependent diabetes, insulin-using diabetes, gestational  
1996 diabetes and non-insulin-using diabetes. Such coverage shall include  
1997 medically necessary equipment, in accordance with the insured  
1998 person's treatment plan, drugs and supplies prescribed by a  
1999 prescribing practitioner, as defined in section 20-571.

2000 Sec. 62. Subsection (a) of section 38a-518e of the general statutes is  
2001 repealed and the following is substituted in lieu thereof (*Effective*  
2002 *October 1, 2017*):

2003 (a) Each group health insurance policy providing coverage of the  
2004 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-

2005 469 delivered, issued for delivery, renewed or continued in this state  
2006 [on or after January 1, 2000,] shall provide coverage for outpatient self-  
2007 management training for the treatment of insulin-dependent diabetes,  
2008 insulin-using diabetes, gestational diabetes and non-insulin-using  
2009 diabetes if the training is prescribed by a licensed health care  
2010 professional who has appropriate state licensing authority to prescribe  
2011 such training. As used in this section, "outpatient self-management  
2012 training" includes, but is not limited to, education and medical  
2013 nutrition therapy. Diabetes self-management training shall be  
2014 provided by a certified, registered or licensed health care professional  
2015 trained in the care and management of diabetes and authorized to  
2016 provide such care within the scope of the professional's practice.

2017 Sec. 63. Section 38a-518l of the general statutes is repealed and the  
2018 following is substituted in lieu thereof (*Effective October 1, 2017*):

2019 Each group health insurance policy providing coverage of the type  
2020 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
2021 delivered, issued for delivery, amended, renewed or continued in this  
2022 state [on or after January 1, 2010,] that provides coverage for  
2023 prescription eye drops, shall not deny coverage for a renewal of  
2024 prescription eye drops when (1) the renewal is requested by the  
2025 insured less than thirty days from the later of (A) the date the original  
2026 prescription was distributed to the insured, or (B) the date the last  
2027 renewal of such prescription was distributed to the insured, and (2) the  
2028 prescribing physician, prescribing advanced practice registered nurse  
2029 or prescribing optometrist indicates on the original prescription that  
2030 additional quantities are needed and the renewal requested by the  
2031 insured does not exceed the number of additional quantities needed.

2032 Sec. 64. Section 38a-520 of the general statutes is repealed and the  
2033 following is substituted in lieu thereof (*Effective October 1, 2017*):

2034 (a) Each group health insurance policy providing coverage of the  
2035 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section  
2036 38a-469 delivered, issued for delivery, renewed, amended or continued  
2037 in this state shall provide coverage providing reimbursement for home

2038 health care to residents in this state.

2039 (b) For the purposes of this section [,"hospital"] and section 38a-494:

2040 (1) "Hospital" means an institution [which] that is primarily  
2041 engaged in providing, by or under the supervision of physicians, to  
2042 inpatients [(1)] (A) diagnostic, surgical and therapeutic services for  
2043 medical diagnosis, treatment and care of injured, disabled or sick  
2044 persons, or [(2)] (B) medical rehabilitation services for the  
2045 rehabilitation of injured, disabled or sick persons. [, provided  
2046 "hospital" shall] "Hospital" does not include a residential care home,  
2047 nursing home, rest home or alcohol or drug treatment facility, as  
2048 defined in section 19a-490; [. For the purposes of this section and  
2049 section 38a-494, "home health care"]

2050 (2) "Home health care" means the continued care and treatment of a  
2051 covered person who is under the care of a physician or an advanced  
2052 practice registered nurse but only if (A) continued hospitalization  
2053 would otherwise have been required if home health care was not  
2054 provided, except in the case of a covered person diagnosed by a  
2055 physician or an advanced practice registered nurse as terminally ill  
2056 with a prognosis of six months or less to live, and (B) the plan covering  
2057 the home health care is established and approved in writing by such  
2058 physician or advanced practice registered nurse within seven days  
2059 following termination of a hospital confinement as a resident inpatient  
2060 for the same or a related condition for which the covered person was  
2061 hospitalized, except that in the case of a covered person diagnosed by  
2062 a physician or an advanced practice registered nurse as terminally ill  
2063 with a prognosis of six months or less to live, such plan may be so  
2064 established and approved at any time irrespective of whether such  
2065 covered person was so confined or, if such covered person was so  
2066 confined, irrespective of such seven-day period, and (C) such home  
2067 health care is commenced within seven days following discharge,  
2068 except in the case of a covered person diagnosed by a physician or an  
2069 advanced practice registered nurse as terminally ill with a prognosis of  
2070 six months or less to live;

2071       (3) "Home health agency" means an agency or organization that  
2072 meets each of the following requirements: (A) It is primarily engaged  
2073 in and is federally certified as a home health agency and duly licensed,  
2074 if such licensing is required, by the appropriate licensing authority, to  
2075 provide nursing and other therapeutic services; (B) its policies are  
2076 established by a professional group associated with such agency or  
2077 organization, including at least one physician or advanced practice  
2078 registered nurse and at least one registered nurse, to govern the  
2079 services provided; (C) it provides for full-time supervision of such  
2080 services by a physician, an advanced practice registered nurse or a  
2081 registered nurse; (D) it maintains a complete medical record on each  
2082 patient; and (E) it has an administrator; and

2083       (4) "Medical social services" means services rendered, under the  
2084 direction of a physician or an advanced practice registered nurse, by a  
2085 qualified social worker holding a master's degree from an accredited  
2086 school of social work, including, but not limited to, (A) assessment of  
2087 the social, psychological and family problems related to or arising out  
2088 of such covered person's illness and treatment, (B) appropriate action  
2089 and utilization of community resources to assist in resolving such  
2090 problems, and (C) participation in the development of the overall plan  
2091 of treatment for such covered person.

2092       (c) Home health care shall be provided by a home health agency.  
2093 [The term "home health agency" means an agency or organization that  
2094 meets each of the following requirements: (1) It is primarily engaged in  
2095 and is federally certified as a home health agency and duly licensed, if  
2096 such licensing is required, by the appropriate licensing authority, to  
2097 provide nursing and other therapeutic services, (2) its policies are  
2098 established by a professional group associated with such agency or  
2099 organization, including at least one physician or advanced practice  
2100 registered nurse and at least one registered nurse, to govern the  
2101 services provided, (3) it provides for full-time supervision of such  
2102 services by a physician, an advanced practice registered nurse or a  
2103 registered nurse, (4) it maintains a complete medical record on each  
2104 patient, and (5) it has an administrator.]



2105 (d) Home health care shall consist of, but shall not be limited to, the  
2106 following: (1) Part-time or intermittent nursing care by a registered  
2107 nurse or by a licensed practical nurse under the supervision of a  
2108 registered nurse, if the services of a registered nurse are not available;  
2109 (2) part-time or intermittent home health aide services, consisting  
2110 primarily of patient care of a medical or therapeutic nature by other  
2111 than a registered or licensed practical nurse; (3) physical, occupational  
2112 or speech therapy; (4) medical supplies, drugs and medicines  
2113 prescribed by a physician, an advanced practice registered nurse or a  
2114 physician assistant and laboratory services to the extent such charges  
2115 would have been covered under the policy or contract if the covered  
2116 person had remained or had been confined in the hospital; (5) medical  
2117 social services [, as hereinafter defined,] provided to or for the benefit  
2118 of a covered person diagnosed by a physician or an advanced practice  
2119 registered nurse as terminally ill with a prognosis of six months or less  
2120 to live. [Medical social services are defined to mean services rendered,  
2121 under the direction of a physician or an advanced practice registered  
2122 nurse by a qualified social worker holding a master's degree from an  
2123 accredited school of social work, including but not limited to (A)  
2124 assessment of the social, psychological and family problems related to  
2125 or arising out of such covered person's illness and treatment; (B)  
2126 appropriate action and utilization of community resources to assist in  
2127 resolving such problems; (C) participation in the development of the  
2128 overall plan of treatment for such covered person.]

2129 (e) The policy may contain a limitation on the number of home  
2130 health care visits for which benefits are payable, but the number of  
2131 such visits shall not be less than eighty in any calendar year or in any  
2132 continuous period of twelve months for each person covered under a  
2133 policy, except in the case of a covered person diagnosed by a physician  
2134 or an advanced practice registered nurse as terminally ill with a  
2135 prognosis of six months or less to live, the yearly benefit for medical  
2136 social services shall not exceed two hundred dollars. Each visit by a  
2137 representative of a home health agency shall be considered as one  
2138 home health care visit [;] and four hours of home health aide service  
2139 shall be considered as one home health care visit.

2140 (f) Home health care benefits may be subject to an annual deductible  
2141 of not more than fifty dollars for each person covered under a policy  
2142 and may be subject to a coinsurance provision that provides for  
2143 coverage of not less than seventy-five per cent of the reasonable  
2144 charges for such services. Such policy may also contain reasonable  
2145 limitations and exclusions applicable to home health care coverage. A  
2146 ["high deductible health plan"] high deductible plan, as defined in  
2147 Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of  
2148 1986, or any subsequent corresponding internal revenue code of the  
2149 United States, as amended from time to time, [amended,] used to  
2150 establish a ["medical savings account" or "Archer MSA"] medical  
2151 savings account or an Archer MSA pursuant to Section 220 of said  
2152 Internal Revenue Code or a ["health savings account"] health savings  
2153 account pursuant to Section 223 of said Internal Revenue Code shall  
2154 not be subject to the deductible limits set forth in this subsection.

2155 (g) No policy, except any major medical expense policy as described  
2156 in subsection (j) of this section, shall be required to provide home  
2157 health care coverage to persons eligible for Medicare.

2158 (h) No insurer, hospital service corporation or health care center  
2159 shall be required to provide benefits beyond the maximum amount  
2160 limits contained in its policy.

2161 (i) If a person is eligible for home health care coverage under more  
2162 than one policy, the home health care benefits shall only be provided  
2163 by that policy that would have provided the greatest benefits for  
2164 hospitalization if the person had remained or had been hospitalized.

2165 (j) Each major medical expense policy delivered, issued for delivery,  
2166 renewed, amended or continued in this state shall provide coverage in  
2167 accordance with the provisions of this section for home health care to  
2168 residents in this state whose benefits are no longer provided under  
2169 Medicare or any applicable individual or group health insurance  
2170 policy.

2171 Sec. 65. Subsection (b) of section 38a-522 of the general statutes is

2172 repealed and the following is substituted in lieu thereof (*Effective*  
2173 *October 1, 2017*):

2174 (b) No insurance company, fraternal benefit society, hospital service  
2175 corporation, medical service corporation or health care center may  
2176 deliver or issue for delivery any Medicare supplement policy that has  
2177 an anticipated loss ratio of less than seventy per cent for any group  
2178 Medicare supplement policy except that a minimum anticipated loss  
2179 ratio of seventy-five per cent shall be required for any group Medicare  
2180 supplement policy defined in Section 1882(g) of Title XVIII of the  
2181 Social Security Act, 42 USC 1395ss(g), as amended from time to time.  
2182 No such company, society, corporation or center may deliver or issue  
2183 for delivery any Medicare supplement policy without providing, at the  
2184 time of solicitation or application for the purchase or sale of such  
2185 coverage, full and fair disclosure of any coverage supplementing or  
2186 duplicating Medicare benefits.

2187 Sec. 66. Subsection (a) of section 38a-526a of the general statutes is  
2188 repealed and the following is substituted in lieu thereof (*Effective*  
2189 *October 1, 2017*):

2190 (a) As used in this section, "telehealth" has the same meaning as  
2191 provided in section 19a-906.

2192 Sec. 67. Subsections (a) and (b) of section 38a-528 of the general  
2193 statutes are repealed and the following is substituted in lieu thereof  
2194 (*Effective October 1, 2017*):

2195 (a) (1) As used in this section, "long-term care policy" means any  
2196 group health insurance policy or certificate delivered or issued for  
2197 delivery to any resident of this state on or after July 1, 1986, that is  
2198 designed to provide, within the terms and conditions of the policy or  
2199 certificate, benefits on an expense-incurred, indemnity or prepaid basis  
2200 for necessary care or treatment of an injury, illness or loss of functional  
2201 capacity provided by a certified or licensed health care provider in a  
2202 setting other than an acute care hospital, for at least one year after a  
2203 reasonable elimination period. A long-term care policy shall provide

2204 benefits for confinement in a nursing home or confinement in the  
2205 insured's own home or both. Any additional benefits provided shall be  
2206 related to long-term treatment of an injury, illness or loss of functional  
2207 capacity. "Long-term care policy" [shall] does not include any such  
2208 policy or certificate that is offered primarily to provide basic Medicare  
2209 supplement coverage, basic medical-surgical expense coverage,  
2210 hospital confinement indemnity coverage, major medical expense  
2211 coverage, disability income protection coverage, accident only  
2212 coverage, specified accident coverage or limited benefit health  
2213 coverage.

2214 (2) (A) No insurance company, fraternal benefit society, hospital  
2215 service corporation, medical service corporation or health care center  
2216 delivering, issuing for delivery, renewing, continuing or amending any  
2217 long-term care policy in this state may refuse to accept, or refuse to  
2218 make reimbursement pursuant to, a claim for benefits submitted by or  
2219 prepared with the assistance of a managed residential community, as  
2220 defined in section 19a-693, in accordance with subdivision (7) of  
2221 subsection (a) of section 19a-694, solely because such claim for benefits  
2222 was submitted by or prepared with the assistance of a managed  
2223 residential community.

2224 (B) Each insurance company, fraternal benefit society, hospital  
2225 service corporation, medical service corporation or health care center  
2226 delivering, issuing for delivery, renewing, continuing or amending any  
2227 long-term care policy in this state shall, upon receipt of a written  
2228 authorization executed by the insured, (i) disclose information to a  
2229 managed residential community for the purpose of determining such  
2230 insured's eligibility for an insurance benefit or payment, and (ii)  
2231 provide a copy of the initial acceptance or declination of a claim for  
2232 benefits to the managed residential community at the same time such  
2233 acceptance or declination is made to the insured.

2234 (b) (1) No insurance company, fraternal benefit society, hospital  
2235 service corporation, medical service corporation or health care center  
2236 may deliver or issue for delivery any long-term care policy or

2237 certificate that has a loss ratio of less than sixty-five per cent for any  
2238 group long-term care policy. An issuer shall not use or change  
2239 premium rates for a long-term care policy or certificate unless the rates  
2240 have been filed with the Insurance Commissioner. Deviations in rates  
2241 to reflect policyholder experience shall be permitted, provided each  
2242 policy form shall meet the loss ratio requirement of this section. Any  
2243 rate filings or rate revisions shall demonstrate that anticipated claims  
2244 in relation to premiums when combined with actual experience to date  
2245 can be expected to comply with the loss ratio requirement of this  
2246 section. On an annual basis, an insurer shall submit to the Insurance  
2247 Commissioner an actuarial certification of the insurer's continuing  
2248 compliance with the loss ratio requirement of this section. Any rate or  
2249 rate revision may be disapproved if the commissioner determines that  
2250 the loss ratio requirement will not be met over the lifetime of the policy  
2251 form using reasonable assumptions.

2252 (2) (A) Any insurance company, fraternal benefit society, [health]  
2253 hospital service corporation, medical service corporation or health care  
2254 center that files a rate filing for an increase in premium rates for a long-  
2255 term care policy that is for twenty per cent or more shall spread the  
2256 increase over a period of not less than three years. Such company,  
2257 society, corporation or center shall use a periodic rate increase that is  
2258 actuarially equivalent to a single rate increase and a current interest  
2259 rate for the period chosen.

2260 (B) Prior to implementing a premium rate increase, each such  
2261 company, society, corporation or center shall:

2262 (i) Notify its certificate holders of such premium rate increase and  
2263 make available to such certificate holders the additional choice of  
2264 reducing the policy benefits to reduce the premium rate. Such notice  
2265 shall include a description of such policy benefit reductions. The  
2266 premium rates for any benefit reductions shall be based on the new  
2267 premium rate schedule;

2268 (ii) Provide certificate holders not less than thirty calendar days to  
2269 elect a reduction in policy benefits; and

2270 (iii) Include a statement in such notice that if a certificate holder fails  
2271 to elect a reduction in policy benefits by the end of the notice period  
2272 and has not cancelled the policy, the certificate holder will be deemed  
2273 to have elected to retain the existing policy benefits.

2274 Sec. 68. Subsection (a) of section 38a-530a of the general statutes is  
2275 repealed and the following is substituted in lieu thereof (*Effective*  
2276 *October 1, 2017*):

2277 (a) No group health insurance plan [, as defined in subdivision (1) of  
2278 subsection (a) of section 38a-476,] or insurance arrangement, as both  
2279 terms are defined in [subdivision (2) of subsection (a) of] section 38a-  
2280 476, as amended by this act, may refuse to cover a group health  
2281 insurance applicant due to breast cancer if such applicant has  
2282 remained free from breast cancer for at least five years prior to the  
2283 applicant's request for group health insurance coverage. The group  
2284 health insurance carrier may require that the applicant submit to a  
2285 physical examination.

2286 Sec. 69. Subsection (b) of section 38a-530c of the general statutes is  
2287 repealed and the following is substituted in lieu thereof (*Effective*  
2288 *October 1, 2017*):

2289 (b) Each group health insurance carrier that offers maternity  
2290 benefits shall provide coverage of a minimum of forty-eight hours of  
2291 inpatient care for a mother and her newborn infant following a vaginal  
2292 delivery and a minimum of ninety-six hours of inpatient care for a  
2293 mother and her newborn infant following a caesarean delivery. The  
2294 time periods shall commence at the time of delivery.

2295 Sec. 70. Subsection (e) of section 38a-530c of the general statutes is  
2296 repealed and the following is substituted in lieu thereof (*Effective*  
2297 *October 1, 2017*):

2298 (e) No group health insurance carrier subject to this section shall  
2299 require prior authorization for the interhospital transfer of (1) a  
2300 newborn infant experiencing a life-threatening emergency or

2301 condition, or (2) the hospitalized mother of such newborn infant to  
2302 accompany her newborn infant.

2303 Sec. 71. Section 38a-532 of the general statutes is repealed and the  
2304 following is substituted in lieu thereof (*Effective October 1, 2017*):

2305 Any person who is insured under any policy of group health  
2306 insurance [is permitted to] may make an assignment of all or any part  
2307 of [his] such insured's incidents of ownership in such insurance,  
2308 including, without limitation, any right to designate a beneficiary or  
2309 beneficiaries thereunder and any right to have an individual policy  
2310 issued upon termination either of employment or of said policy of  
2311 group health insurance, if applicable, [provided] except that the  
2312 insurer or group policyholder may prohibit or restrict such assignment  
2313 by appropriate policy provisions. Such an assignment, subject to the  
2314 terms of the policy or agreement between the group policyholder and  
2315 the insurer, is valid for the purpose of vesting in the assignee, in  
2316 accordance with any provisions included therein as to the time at  
2317 which it is to be effective, all rights, benefits and incidents of  
2318 ownership conferred under the policy and shall entitle the insurer to  
2319 deal with the assignee as the owner of such rights, benefits and  
2320 incidents of ownership, provided the insurer shall not be affected by  
2321 any assignment until [he] the insurer has received written notice  
2322 thereof.

2323 Sec. 72. Subdivision (7) of section 38a-564 of the general statutes is  
2324 repealed and the following is substituted in lieu thereof (*Effective*  
2325 *October 1, 2017*):

2326 (7) "Health insurance plan" means any hospital and medical expense  
2327 incurred policy, hospital or medical service plan contract and health  
2328 care center subscriber contract. "Health insurance plan" does not  
2329 include (A) accident only, credit, dental, vision, Medicare supplement,  
2330 long-term care or disability insurance, hospital indemnity coverage,  
2331 coverage issued as a supplement to liability insurance, insurance  
2332 arising out of a workers' compensation or similar law, automobile  
2333 medical-payments insurance, or insurance under which beneficiaries

2334 are payable without regard to fault and which is statutorily required to  
2335 be contained in any liability insurance policy or equivalent self-  
2336 insurance, or (B) policies of specified disease or limited benefit health  
2337 insurance, provided [that] the carrier offering such policies files on or  
2338 before March first of each year a certification with the commissioner  
2339 that contains the following: (i) A statement from the carrier certifying  
2340 that such policies are being offered and marketed as supplemental  
2341 health insurance and not as a substitute for hospital or medical  
2342 expense insurance; (ii) a summary description of each such policy  
2343 including the average annual premium rates, or range of premium  
2344 rates in cases where premiums vary by age, gender or other factors,  
2345 charged for such policies in the state; and (iii) in the case of a policy  
2346 that is described in this subparagraph and that is offered for the first  
2347 time in this state on or after October 1, 1993, the carrier files with the  
2348 commissioner the information and statement required in this  
2349 subparagraph at least thirty days prior to the date such policy is issued  
2350 or delivered in this state.

2351 Sec. 73. Subdivision (2) of subsection (d) of section 38a-569 of the  
2352 general statutes is repealed and the following is substituted in lieu  
2353 thereof (*Effective October 1, 2017*):

2354 (2) Any person or member made a party to any action, suit or  
2355 proceeding because the person or member served on the board or on a  
2356 committee or was an officer or employee of the pool shall be held  
2357 harmless and be indemnified by the program against all liability and  
2358 costs, including the amounts of judgments, settlements, fines or  
2359 penalties, and expenses and reasonable attorney's fees incurred in  
2360 connection with the action, suit or proceeding. The indemnification  
2361 shall not be provided on any matter in which the person or member is  
2362 finally adjudged in the action, suit or proceeding to have committed a  
2363 breach of duty involving gross negligence, dishonesty, wilful  
2364 misfeasance or reckless disregard of the responsibilities of office. Costs  
2365 and expenses of the indemnification shall be prorated and paid for by  
2366 all members. The Insurance Commissioner may retain actuarial  
2367 consultants necessary to carry out said commissioner's responsibilities



2368 pursuant to this section [,] or section 38a-564, as amended by this act,  
2369 38a-566 or 38a-567, and such expenses shall be paid by the pool  
2370 established in this section.

2371 Sec. 74. Section 38a-582 of the general statutes is repealed and the  
2372 following is substituted in lieu thereof (*Effective October 1, 2017*):

2373 (a) No schedule of charges for enrollee coverage for dental services,  
2374 or any amendment thereto, may be used by a dental plan organization  
2375 until a copy of such schedule or amendment has been filed with the  
2376 commissioner for [his] the commissioner's approval. The commissioner  
2377 may disapprove the schedule of charges at any time if [he] the  
2378 commissioner finds that the charges are excessive, inadequate or  
2379 unfairly discriminatory. If the commissioner disapproves the schedule  
2380 of charges, [he] the commissioner shall notify the dental plan  
2381 organization within sixty days of the date of disapproval and specify  
2382 in the notice the reason for [his] disapproval. A hearing shall be  
2383 granted within twenty days after a request in writing by the dental  
2384 plan organization is received by the commissioner. It shall be unlawful  
2385 for any dental plan organization whose schedule of charges has been  
2386 disapproved to effect any contract or issue any subscription certificate  
2387 [which] that uses the disapproved schedule of charges until a revised  
2388 schedule of charges has been approved. Any dental plan organization  
2389 aggrieved by the action of the commissioner pursuant to this section  
2390 may appeal therefrom, in accordance with the provisions of section 4-  
2391 183.

2392 (b) Charges shall be established in accordance with actuarial  
2393 principles, but charges applicable to an enrollee shall not be  
2394 individually determined based on the status of [his] the enrollee's  
2395 health.

2396 Sec. 75. Subsection (b) of section 38a-672 of the general statutes is  
2397 repealed and the following is substituted in lieu thereof (*Effective*  
2398 *October 1, 2017*):

2399 (b) To obtain and retain a license, a rating organization shall provide

2400 satisfactory evidence to the Insurance Commissioner that it will: (1)  
2401 Permit any admitted insurer to become a member of or a subscriber to  
2402 such rating organization at a reasonable cost and without  
2403 discrimination, or withdraw therefrom; (2) neither have nor adopt any  
2404 rule or exact any agreement, the effect of which would be to require  
2405 any member or subscriber as a condition to membership or  
2406 subscribership, to adhere to its rates, rating plans, rating systems,  
2407 underwriting rules, or policy or bond forms; (3) neither adopt any rule  
2408 nor exact any agreement the effect of which would be to prohibit or  
2409 regulate the payment of dividends, savings or unabsorbed premium  
2410 deposits allowed or returned by insurers to their policyholders,  
2411 members or subscribers; (4) neither practice nor sanction any plan or  
2412 act of boycott, coercion or intimidation; (5) neither enter into nor  
2413 sanction any contract or act by which any person is restrained from  
2414 lawfully engaging in the insurance business; (6) notify the Insurance  
2415 Commissioner promptly of every change in its constitution, its articles  
2416 of incorporation, agreement or association, and of its bylaws, rules and  
2417 regulations governing the conduct of its business, its list of members  
2418 and subscribers and the name and address of the resident of this state  
2419 designated by it upon whom notices or orders of said commissioner or  
2420 process affecting such organization may be served; (7) with respect to  
2421 personal and commercial risk insurance, neither compile for nor  
2422 distribute to insurers generally, recommendations relating to rates that  
2423 include profit, general and other acquisition expenses, commission and  
2424 brokerage, taxes or licenses and fees, nor file rates, supplementary rate  
2425 information or supporting information on behalf of an insurer that  
2426 includes profit, general and other acquisition expenses, commission  
2427 and brokerage, taxes or licenses and fees. [, provided that the] The  
2428 provisions of this subdivision may be waived by the Insurance  
2429 Commissioner when it would be in the public interest and shall not  
2430 apply to residual markets; and (8) comply with the provisions of  
2431 section 38a-675, as amended by this act. Any rating organization may,  
2432 upon the request of any insurer, produce rates for such insurer based  
2433 upon such insurer's exposure, loss, expense and profit data. The  
2434 provisions of subdivision (7) of this subsection shall be applicable to

2435 services rendered by insurance rating and advisory organizations in  
2436 relation to workers' compensation insurance on and after October 1,  
2437 1989, and to other such services on and after July 1, 1990.

2438 Sec. 76. Subsection (c) of section 38a-673 of the general statutes is  
2439 repealed and the following is substituted in lieu thereof (*Effective*  
2440 *October 1, 2017*):

2441 (c) With respect to personal and commercial risk insurance, no such  
2442 advisory organization may compile for or distribute to insurers  
2443 generally, recommendations relating to rates that include profit,  
2444 general and other acquisition expenses, commission and brokerage,  
2445 taxes or licenses and fees, nor file rates, supplementary rate  
2446 information or supporting information on behalf of an insurer that  
2447 includes profit, general and other acquisition expenses, commission  
2448 and brokerage, taxes or licenses and fees. [, provided that the] The  
2449 provisions of this subsection may be waived by the Insurance  
2450 Commissioner when it would be in the public interest and shall not  
2451 apply to residual markets. Any advisory organization may, upon the  
2452 request of any insurer, produce rates for such insurer based upon such  
2453 insurer's exposure, loss, expense and profit data. The provisions of this  
2454 subsection shall be applicable to services rendered by insurance rating  
2455 and advisory organizations in relation to workers' compensation  
2456 insurance on and after October 1, 1989, and to other such services on  
2457 and after July 1, 1990.

2458 Sec. 77. Subsection (b) of section 38a-675 of the general statutes is  
2459 repealed and the following is substituted in lieu thereof (*Effective*  
2460 *October 1, 2017*):

2461 (b) The Insurance Commissioner shall approve reasonable rules and  
2462 statistical plans, reasonably adapted to each of the rating systems used,  
2463 and which shall thereafter be used by each admitted insurer in the  
2464 recording and reporting of its loss and country-wide expense  
2465 experience, in order that the experience of all insurers may be made  
2466 available at least annually. Such rules and plans may also provide for  
2467 the recording and reporting of expense experience items which are

2468 specially applicable to this state and are not susceptible of  
2469 determination by a prorating of country-wide expense experience. In  
2470 approving such rules and plans, the commissioner shall give due  
2471 consideration to the rating systems in use in this state and in other  
2472 states. No insurer shall be required to record or report its loss  
2473 experience on a classification basis that is inconsistent with the rating  
2474 system used by it, [provided] except that with respect to private  
2475 passenger nonfleet automobile insurance, the commissioner may  
2476 require that claims and loss experience data be allocated, compiled and  
2477 reported by town. The commissioner may designate one or more  
2478 rating organizations or other agencies to assist him in gathering such  
2479 experience and making compilations thereof, and such compilations  
2480 shall be made available, subject to reasonable rules promulgated by the  
2481 commissioner, to insurers and rating organizations.

2482       Sec. 78. Subdivision (3) of subsection (b) of section 38a-686 of the  
2483 general statutes is repealed and the following is substituted in lieu  
2484 thereof (*Effective October 1, 2017*):

2485       (3) Risks may be grouped by classifications for the establishment of  
2486 rates and minimum premiums, provided [that] with respect to private  
2487 passenger nonfleet automobile insurance, any change in territorial  
2488 classifications shall be subject to prior approval by the Insurance  
2489 Commissioner, and provided no surcharge on any motor vehicle  
2490 liability or physical damage insurance premium shall be assigned for  
2491 (A) any accident involving only property damage of one thousand  
2492 dollars or less, (B) the first accident involving only property damage of  
2493 more than one thousand dollars which would otherwise result in a  
2494 surcharge to the policy of the insured, within the experience period set  
2495 forth in the insurer's safe driver classification plan, (C) any violation of  
2496 section 14-219 unless such violation results in the suspension or  
2497 revocation of the operator's license under section 14-111b, (D) less than  
2498 three violations of section 14-218a within any one-year period, (E) any  
2499 accident caused by an operator other than the named insured, a  
2500 relative residing in the named insured's household, or a person who  
2501 customarily operates the insured vehicle, (F) the first or second

2502 accident within the current experience period in relation to which the  
2503 insured was not convicted of a moving traffic violation and was not at  
2504 fault, or (G) any motor vehicle infraction. Subparagraph (G) of this  
2505 subdivision shall not be applicable to any plan established pursuant to  
2506 section 38a-329. Classification rates may be modified to produce rates  
2507 for individual risks in accordance with rating plans that provide for  
2508 recognition of variations in hazards or expense provisions or both.  
2509 Such rating plans may include application of the judgment of the  
2510 insurer and may measure any differences among risks that can be  
2511 demonstrated to have a probable effect upon losses or expenses.

2512 Sec. 79. Section 38a-688 of the general statutes is repealed and the  
2513 following is substituted in lieu thereof (*Effective October 1, 2017*):

2514 (a) The following procedures shall apply with respect to rates  
2515 pertaining to personal risk insurance and residual markets:

2516 (1) In a competitive market, every insurer shall file with the  
2517 commissioner all rates and supplementary rate information to be used  
2518 in this state, provided [that] such rates and information need not be  
2519 filed for inland marine risks [which] that by general custom of the  
2520 business are not written according to manual rules or rating plans. No  
2521 such filings may be made by a rating organization on behalf of any  
2522 insurer. Such rates and supplementary rate information shall be filed  
2523 by the effective date of the filing or the date that premium billing  
2524 notices reflecting the new rates are sent to insureds or agents,  
2525 whichever is earlier. In a competitive market, if the commissioner  
2526 finds, after a hearing, that an insurer's rates require closer supervision  
2527 because of the insurer's financial condition or unfairly discriminatory  
2528 rating practices, the insurer shall file with the commissioner at least  
2529 thirty days before the effective date, all such rates and such  
2530 supplementary rate information and supporting information as  
2531 prescribed by the commissioner. Upon application by the filer, the  
2532 commissioner may authorize an earlier effective date for the filing.

2533 (2) In a noncompetitive market, every insurer shall file with the  
2534 commissioner all rates and supplementary rate information for that

2535 market and such supporting information as is required by the  
2536 commissioner. For purposes of subsection (d) of section 7-479e,  
2537 sections 38a-341, as amended by this act, 38a-387, 38a-665, subsection  
2538 (b) of section 38a-672, as amended by this act, and sections 38a-673, as  
2539 amended by this act, 38a-675, as amended by this act, 38a-676 and 38a-  
2540 686 to 38a-694, inclusive, as amended by this act, residual markets, title  
2541 insurance and credit property insurance are deemed to be  
2542 noncompetitive markets. All rates and supplementary rate information  
2543 and such supporting information as is required by the commissioner,  
2544 shall also be filed with the commissioner for insurance provided  
2545 pursuant to section 38a-328, 38a-329 or 38a-670. Such rates and  
2546 supplementary rate information and supporting information required  
2547 by the commissioner shall be on file with the commissioner for a  
2548 waiting period of thirty days before it becomes effective, which period  
2549 may be extended by the commissioner for an additional period not to  
2550 exceed thirty days if the commissioner gives written notice within such  
2551 waiting period to the insurer or rating organization [which] that made  
2552 the filing that the commissioner needs such additional time for the  
2553 consideration of such filing. Upon written application by such insurer  
2554 or rating organization, the commissioner may authorize a filing  
2555 [which] that the commissioner has reviewed to become effective before  
2556 the expiration of the waiting period or any extension thereof. A filing  
2557 shall be deemed to meet the requirements of sections 38a-663 to 38a-  
2558 696, inclusive, unless disapproved by the commissioner within the  
2559 waiting period or any extension thereof. If, within the waiting period  
2560 or any extension thereof, the commissioner finds that a filing does not  
2561 meet the requirements of sections 38a-663 to 38a-696, inclusive, the  
2562 commissioner shall send to the insurer or rating organization which  
2563 made such filing written notice of disapproval of such filing,  
2564 specifying therein in what respects the commissioner finds such filing  
2565 fails to meet the requirements of sections 38a-663 to 38a-696, inclusive,  
2566 and stating that such filing shall not become effective. Such finding of  
2567 the commissioner shall be subject to review as provided in section 38a-  
2568 19.

2569 (3) An insurer may file rates by reference, with or without deviation,

2570 to rates charged by another insurer [which] that were filed and are in  
2571 effect if the insurer's direct written premium for the applicable line of  
2572 insurance is less than one-half of one per cent of the total state-wide  
2573 direct written premium for that line, as determined from the annual  
2574 statements filed by insurers licensed to do business in this state and as  
2575 calculated by the National Association of Insurance Commissioners  
2576 from its data base. Supporting information shall not be required for  
2577 rates filed by reference pursuant to this subsection. For purposes of  
2578 this subdivision, [the term] "insurer" [shall include] includes two or  
2579 more admitted insurers having a common ownership or operating in  
2580 this state under common management or control.

2581 (4) Rates filed pursuant to this section shall be filed in such form  
2582 and manner as is prescribed by the commissioner. Whenever a filing  
2583 made pursuant to subdivision (1) or (2) of subsection (a) of this section  
2584 is not accompanied by the information upon which the insurer  
2585 supports such filing and the commissioner does not have sufficient  
2586 information to determine whether such filing meets the requirements  
2587 of sections 38a-663 to 38a-696, inclusive, the commissioner shall  
2588 require such insurer to furnish the information upon which it supports  
2589 such filing and in such event the waiting period shall commence as of  
2590 the date such information is furnished. The information furnished in  
2591 support of a filing may include (A) the experience or judgment of the  
2592 insurer making the filing, (B) its interpretation of any statistical data it  
2593 relies upon, (C) the experience of other insurers, or (D) any other  
2594 relevant factors.

2595 (5) All rates, supplementary rate information and any supporting  
2596 information for risks filed under subsection (d) of section 7-479e,  
2597 sections 38a-341, as amended by this act, 38a-387, 38a-665, subsection  
2598 (b) of section 38a-672, as amended by this act, and sections 38a-673, as  
2599 amended by this act, 38a-675, as amended by this act, 38a-676 and 38a-  
2600 686 to 38a-694, inclusive, as amended by this act, shall, as soon as filed,  
2601 be open to public inspection at any reasonable time. Copies may be  
2602 obtained by any person on request and upon payment of a reasonable  
2603 charge.

2604 (b) Rates for insurance described in subsection (a) of this section  
2605 shall be subject to review as follows:

2606 (1) Rates subject to prefiling under subdivision (1) or (2) of  
2607 subsection (a) of this section may be reviewed and disapproved before  
2608 their effective date, except that rates for insurance provided pursuant  
2609 to section 38a-328, 38a-329 and 38a-670 shall not be effective until  
2610 approved by the commissioner. Any rate may be reviewed and  
2611 disapproved subsequent to its effective date.

2612 (2) The commissioner may disapprove a rate if the insurer fails to  
2613 comply with the filing requirements of this section. The commissioner  
2614 shall disapprove a rate for use in a competitive market if [he] the  
2615 commissioner finds that the rate is inadequate or unfairly  
2616 discriminatory under subsection (a) of section 38a-686. The  
2617 commissioner shall disapprove a rate for use in a noncompetitive or  
2618 residual market if [he] the commissioner finds the rate is excessive,  
2619 inadequate or unfairly discriminatory under subsection (a) of section  
2620 38a-686.

2621 (3) If the commissioner finds that a reasonable degree of  
2622 competition does not exist in a market in accordance with section 38a-  
2623 687, [he] the commissioner may require that the insurers in that market  
2624 file supporting information with respect to existing rates. If the  
2625 commissioner believes that such rates may violate any of the  
2626 requirements of subsection (d) of section 7-479e, sections 38a-341, as  
2627 amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-  
2628 672, as amended by this act, or sections 38a-673, as amended by this  
2629 act, 38a-675, as amended by this act, 38a-676, or 38a-686 to 38a-694,  
2630 inclusive, [he] as amended by this act, the commissioner may proceed  
2631 as provided in section 38a-678. If the commissioner believes that rates  
2632 in a competitive market violate the inadequacy or unfair  
2633 discrimination standards in section 38a-686, as amended by this act, or  
2634 any other applicable requirement of subsection (d) of section 7-479e,  
2635 section 38a-341, as amended by this act, 38a-387, 38a-665, subsection  
2636 (b) of section 38a-672, as amended by this act, or sections 38a-673, as



2637 amended by this act, 38a-675, as amended by this act, 38a-676, or 38a-  
2638 686 to 38a-694, inclusive, [he] as amended by this act, the  
2639 commissioner may require the insurers in that market to file  
2640 supporting information with respect to existing rates. If after  
2641 reviewing the supporting information, the commissioner continues to  
2642 believe that such rates may violate these requirements, [he] the  
2643 commissioner may proceed as provided in section 38a-678. The  
2644 commissioner may disapprove, without hearing, rates prefiled  
2645 pursuant to subdivision (1) or (2) of subsection (a) of this section that  
2646 have not become effective, provided [that] the insurer whose rates  
2647 have been disapproved shall be given a hearing pursuant to section  
2648 38a-19.

2649 (4) If the commissioner disapproves a rate, [he] the commissioner  
2650 shall issue an order specifying the respects in which it fails to meet the  
2651 requirements of subsection (d) of section 7-479e, section 38a-341, as  
2652 amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-  
2653 672, as amended by this act, and sections 38a-673, as amended by this  
2654 act, 38a-675, as amended by this act, 38a-676, and 38a-686 to 38a-694,  
2655 inclusive, as amended by this act. For rates in effect at the time of the  
2656 disapproval, the commissioner shall state, within a reasonable period  
2657 of time, when the further use of such rate in contracts of insurance  
2658 made thereafter shall be prohibited. The commissioner shall issue such  
2659 order [shall be issued within] not later than thirty days after the  
2660 hearing or within such reasonable time extension as the commissioner  
2661 may determine. Such order may include a provision for premium  
2662 adjustment for the period after the effective date of the order for  
2663 policies in effect on such date.

2664 (5) Whenever an insurer has no legally effective rates as a result of  
2665 the commissioner's disapproval of rates or other act, the commissioner  
2666 shall specify interim rates. Upon appeal from any such order of the  
2667 commissioner the court may, upon request of the appealing insurer,  
2668 stay such order, provided [that] the insurer places in an escrow  
2669 account the difference, as received, between the disapproved rates and  
2670 the interim rates specified by the commissioner. When new rates

2671 become legally effective, the commissioner shall order the escrowed  
2672 funds to be distributed appropriately, with interest at the legal rate as  
2673 provided in section 37-1, except that minimal refunds to policyholders  
2674 are not required to be distributed.

2675 Sec. 80. Section 38a-702a of the general statutes is repealed and the  
2676 following is substituted in lieu thereof (*Effective October 1, 2017*):

2677 As used in this chapter and chapter 702, unless the context or  
2678 subject matter otherwise require:

2679 (1) "Agent" or "insurance agent" means an insurance producer  
2680 appointed by an insurer to act on the insurer's behalf pursuant to  
2681 section 38a-702m.

2682 (2) "Business entity" means a corporation, association, partnership,  
2683 limited liability company, limited liability partnership, or other legal  
2684 entity.

2685 (3) "Commissioner" means the Insurance Commissioner.

2686 (4) "Home state" means any state or territory of the United States,  
2687 including, but not limited to, the District of Columbia, in which an  
2688 insurance producer maintains the producer's principal place of  
2689 residence or principal place of business and is licensed to act as an  
2690 insurance producer.

2691 (5) "Insurance" means any of the lines of authority contained in this  
2692 title.

2693 (6) "Insurance producer" or "producer" means a person required to  
2694 be licensed under the laws of this state to sell, solicit or negotiate  
2695 insurance.

2696 (7) "Insurer" [means "insurer", as defined] has the same meaning as  
2697 provided in section 38a-1.

2698 (8) "License" means a document issued by the commissioner  
2699 authorizing a person to act as an insurance producer for the lines of

2700 authority specified in the document. The license itself does not create  
2701 any authority, actual, apparent or inherent, in the holder to represent  
2702 or commit an insurance carrier.

2703 (9) "Limited line credit insurance" includes credit life, credit  
2704 disability, credit property, credit unemployment, involuntary  
2705 unemployment, mortgage life, mortgage guaranty, mortgage  
2706 disability, guaranteed automobile protection insurance and any other  
2707 form of insurance offered in connection with an extension of credit that  
2708 is limited to partially or wholly extinguishing that credit obligation  
2709 that the commissioner determines should be designated a form of  
2710 limited line credit insurance.

2711 (10) "Limited line credit insurance producer" means a person who  
2712 sells, solicits or negotiates one or more forms of limited line credit  
2713 insurance coverage to individuals through a master, corporate, group  
2714 or individual policy.

2715 (11) "Limited lines insurance" means [those lines of insurance  
2716 referred to in section 38a-782] credit insurance and travel insurance, or  
2717 any other line of insurance that the commissioner deems necessary to  
2718 recognize for the purpose of complying with section 38a-702g.

2719 (12) "Limited lines producer" means a person authorized by the  
2720 commissioner to sell, solicit or negotiate limited lines insurance.

2721 (13) "Negotiate" means the act of conferring directly with, or  
2722 offering advice directly to, a purchaser or prospective purchaser of a  
2723 particular contract of insurance concerning any of the substantive  
2724 benefits, terms or conditions of the contract, provided the person  
2725 engaged in that act either sells insurance or obtains insurance from  
2726 insurers for purchasers.

2727 (14) "Person" means an individual or a business entity.

2728 (15) "Sell" means to exchange a contract of insurance by any means,  
2729 for money or its equivalent, on behalf of an insurance company.

2730 (16) "Solicit" means attempting to sell insurance or asking or urging  
2731 a person to apply for a particular kind of insurance from a particular  
2732 company.

2733 (17) "Terminate" means the cancellation of the relationship between  
2734 an insurance producer and the insurer or the termination of a  
2735 producer's authority to transact insurance.

2736 (18) "Uniform business entity application" means the National  
2737 Association of Insurance Commissioners uniform business entity  
2738 application for resident and nonresident business entities, as amended  
2739 from time to time.

2740 (19) "Uniform application" means the National Association of  
2741 Insurance Commissioners uniform application for resident and  
2742 nonresident producer licensing, as amended from time to time.

2743 Sec. 81. Subsection (c) of section 38a-712 of the general statutes is  
2744 repealed and the following is substituted in lieu thereof (*Effective*  
2745 *October 1, 2017*):

2746 (c) The commissioner may adopt such reasonable regulations as [he]  
2747 the commissioner deems necessary for the implementation of this  
2748 section and specifically to provide procedures for continuing,  
2749 terminating or restoring the licenses affected.

2750 Sec. 82. Subsection (a) of section 38a-716 of the general statutes is  
2751 repealed and the following is substituted in lieu thereof (*Effective*  
2752 *October 1, 2017*):

2753 (a) If any insurance producer advances, on behalf of an insured,  
2754 premium for a policy to an insurer, [on behalf of an insured,] with  
2755 respect to any property or casualty insurance policy other than one  
2756 providing coverage for homeowners, tenants, private passenger  
2757 nonfleet automobile, mobile manufactured home and other property  
2758 and casualty insurance for personal, family or household needs and  
2759 such insured has not paid the premium due, the producer may request  
2760 cancellation of such policy by the insurer, provided [that] the producer

2761 has sent, by certified or registered mail, return receipt requested, to the  
2762 insured at the address shown on the policy, a written notice [which  
2763 shall include] that includes: (1) The name and address of the insured  
2764 and the insurer, (2) policy number, (3) an itemization of the premium  
2765 due the insurance producer stated separately for each policy or  
2766 endorsement, including separate itemization of all payments received  
2767 for and credits applied to, each policy, (4) a statement of the insurance  
2768 producer's intent to request, in writing, cancellation of the policy by  
2769 the insurer for nonpayment of premium, unless the default is cured  
2770 [within] not later than fifteen days [from] after the date the notice is  
2771 postmarked, (5) a statement specifying that in the event the insured  
2772 submits any written response to the notice, it shall be forwarded to the  
2773 insurer with the request for cancellation. If written response is received  
2774 following submission of written request for cancellation, it shall be  
2775 immediately forwarded to the insurer by the insurance producer. The  
2776 insurer shall reply directly to the insured [within] not later than ten  
2777 days [following] after receipt of the insured's response and forward a  
2778 copy of its response to the producer.

2779 Sec. 83. Subsection (f) of section 38a-720j of the general statutes is  
2780 repealed and the following is substituted in lieu thereof (*Effective*  
2781 *October 1, 2017*):

2782 (f) Any license issued to a third-party administrator shall be in force  
2783 until September thirtieth of each year, unless sooner revoked or  
2784 suspended as provided in this section. The license may be renewed, at  
2785 the discretion of the commissioner, upon payment of the fee specified  
2786 in section 38a-11, and submission of the renewal filing under section  
2787 38a-720l, as amended by this act.

2788 Sec. 84. Subsection (a) of section 38a-720l of the general statutes is  
2789 repealed and the following is substituted in lieu thereof (*Effective*  
2790 *October 1, 2017*):

2791 (a) Each third-party administrator seeking to renew a license issued  
2792 pursuant to section 38a-720j, as amended by this act, shall submit a  
2793 renewal filing in the form and [contain] containing such information as

2794 the commissioner prescribes, including evidence that the surety bond  
2795 required under subdivision (1) of subsection (a) of section 38a-720j  
2796 and, if applicable, subsection (h) of section 38a-720j, remain in force.  
2797 The information contained in such [report] renewal filing shall be  
2798 verified by at least two officers of the third-party administrator.

2799 Sec. 85. Subsection (a) of section 38a-775 of the general statutes is  
2800 repealed and the following is substituted in lieu thereof (*Effective*  
2801 *October 1, 2017*):

2802 (a) As used in this section:

2803 (1) "Bank" has the same meaning as [set forth] provided in section  
2804 36a-2, but does not include a trust company that does not accept  
2805 federally insured deposits and does not engage in insurance sales or  
2806 solicitation activities, either directly or indirectly through a third-party  
2807 marketing organization, that would require such trust company to  
2808 obtain an insurance producer's license under the laws of this state;

2809 (2) "Out-of-state bank" has the same meaning as [set forth] provided  
2810 in section 36a-2, provided the institution (A) maintains in this state a  
2811 branch, as defined in section 36a-410, or (B) engages in insurance sales  
2812 or solicitation activities, either directly or indirectly through a third-  
2813 party marketing organization, that would require the institution to  
2814 obtain an insurance producer's license under the laws of this state, but  
2815 does not include a trust company that does not accept federally  
2816 insured deposits and does not engage in insurance sales or solicitation  
2817 activities, either directly or indirectly through a third-party marketing  
2818 organization, that would require such trust company to obtain an  
2819 insurance producer's license under the laws of this state;

2820 (3) "Subsidiary" has the same meaning as [set forth] provided in  
2821 section 36a-2;

2822 (4) "Insurance" has the same meaning as [set forth] provided in  
2823 section 38a-1, but does not include title insurance;

2824 (5) "Customer" means any person who establishes a deposit, trust,

2825 investment, loan or credit account with a bank, out-of-state bank or  
2826 subsidiary of such bank or out-of-state bank;

2827 (6) "Insurance information" means copies of, or the information  
2828 contained in, insurance policies, binders, rates, declaration pages and  
2829 expiration dates that are acquired by a bank, out-of-state bank or  
2830 subsidiary of such bank or out-of-state bank in connection with its  
2831 lending activities; and

2832 (7) "Insurance producer" has the same meaning as [set forth]  
2833 provided in section 38a-702a, as amended by this act.

2834 Sec. 86. Subdivision (1) of subsection (d) of section 38a-790 of the  
2835 general statutes is repealed and the following is substituted in lieu  
2836 thereof (*Effective October 1, 2017*):

2837 (1) "Motor vehicle" [is defined] has the same meaning as provided in  
2838 section 14-1;

2839 Sec. 87. Subdivision (11) of section 38a-838 of the general statutes is  
2840 repealed and the following is substituted in lieu thereof (*Effective*  
2841 *October 1, 2017*):

2842 (11) "United States" has the same meaning [assigned to it by] as  
2843 provided in section 38a-1.

2844 Sec. 88. Subdivision (16) of section 38a-862 of the general statutes is  
2845 repealed and the following is substituted in lieu thereof (*Effective*  
2846 *October 1, 2017*):

2847 (16) "Premiums" means amounts or considerations, by whatever  
2848 name called, received on covered policies or contracts less premiums,  
2849 considerations and deposits returned thereon, and less dividends and  
2850 experience credits thereon. "Premiums" does not include (A) any  
2851 amounts or considerations received for any policies or contracts or for  
2852 the portions of any policies or contracts for which coverage is not  
2853 provided under subsection (f) of section 38a-860, except that assessable  
2854 premium shall not be reduced on account of subparagraph (C) of

2855 subdivision (2) of subsection (f) of section 38a-860, relating to interest  
2856 limitations, and subdivision (2) of subsection (g) of section 38a-860,  
2857 relating to limitations with respect to any one individual, any one  
2858 participant and any one contract owner; provided [that] further,  
2859 "premiums" [shall] does not include any premiums in excess of five  
2860 million dollars on any unallocated annuity contract not issued under a  
2861 governmental retirement benefit plan established under Section 401,  
2862 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent  
2863 corresponding internal revenue code of the United States, as from time  
2864 to time amended, or (B) with respect to multiple nongroup policies of  
2865 life insurance owned by one owner, whether the policy owner is an  
2866 individual, firm, corporation or other person, and whether the persons  
2867 insured are officers, managers, employees or other persons, premiums  
2868 in excess of five million dollars with respect to such policies or  
2869 contracts, regardless of the number of policies or contracts held by the  
2870 owner;

2871 Sec. 89. Subsection (c) of section 38a-939 of the general statutes is  
2872 repealed and the following is substituted in lieu thereof (*Effective*  
2873 *October 1, 2017*):

2874 (c) Except as provided in this section, a claim may not share in a  
2875 distribution of assets pursuant to this chapter unless it has been  
2876 definitely determined, proved and allowed. A contingent,  
2877 unliquidated or immature claim may share in a distribution of assets  
2878 provided, [that,] as of the time of the allowance or disallowance of the  
2879 claim by the court: (1) If the claim was a contingent claim against the  
2880 insurer as of the date established under section 38a-920, the claimant  
2881 has presented proof of the insurer's obligation to pay reasonably  
2882 satisfactory to the receiver; (2) if the claim was a contingent claim as of  
2883 the date established under section 38a-920 and was based upon a cause  
2884 of action against an insured of the insurer, (A) it may be reasonably  
2885 inferred from proof presented upon the claim that the claimant would  
2886 be able to obtain a judgment, (B) the person has furnished suitable  
2887 proof, unless the court for good cause shown shall otherwise direct,  
2888 that no further valid claims can be made against the insurer arising out



2889 of the cause of action other than those already presented, and (C) the  
2890 total liability of the insurer to all claimants arising out of the same act  
2891 shall be no greater than its total liability would be were it not in  
2892 liquidation. In those cases under subparagraph (C) of this subdivision,  
2893 insureds may include in contingent claims reasonable attorney's fees  
2894 for services rendered after the date of liquidation, in defense of claims  
2895 or suits covered by the insured's policy, provided the attorney's fees  
2896 have been paid by the insured and evidence of payment is presented to  
2897 the receiver; (3) if the claim was unliquidated as of the date established  
2898 under section 38a-920, its amount has been determined, provided such  
2899 determination does not prejudice the orderly administration of the  
2900 liquidation proceeding; or (4) if the claim was immature as of the date  
2901 established under section 38a-920, it shall be discounted at the higher  
2902 of the legal rate of interest accruing on judgments or the rate of interest  
2903 available on United States Treasury securities of approximately the  
2904 same maturity.

2905 Sec. 90. Subsection (e) of section 38a-941 of the general statutes is  
2906 repealed and the following is substituted in lieu thereof (*Effective*  
2907 *October 1, 2017*):

2908 (e) The courts of this state may make special rules of civil procedure  
2909 for disputed claims, provided [that] the rules are not inconsistent with  
2910 this chapter.

2911 Sec. 91. Subdivision (2) of subsection (a) of section 38a-944 of the  
2912 general statutes is repealed and the following is substituted in lieu  
2913 thereof (*Effective October 1, 2017*):

2914 (2) Class 2. The administrative expenses of guaranty associations.  
2915 For purposes of this section such expenses shall be those reasonable  
2916 expenses incurred by guaranty associations where the expenses are not  
2917 payments or expenses [which] that are required to be incurred as  
2918 direct policy benefits in fulfillment of the terms of the insurance  
2919 contract or policy, and that are of the type and nature that, but for the  
2920 activities of the guaranty association otherwise would have been  
2921 incurred by the receiver, including, but not limited to, evaluations of

2922 policy coverage, activities involved in the adjustment and settlement of  
2923 claims under policies, including those of in-house or outside adjusters,  
2924 and the reasonable expenses incurred in connection with the  
2925 arrangements for ongoing coverage through transfer to other insurers,  
2926 policy exchanges or maintaining policies in force. The receiver may in  
2927 his or her sole discretion approve as an administrative expense under  
2928 this section any other reasonable expenses of the guaranty association  
2929 if the receiver finds: (A) The expenses are not expenses required to be  
2930 paid or incurred as direct policy benefits by the terms of the policy,  
2931 and (B) the expenses were incurred in furtherance of activities that  
2932 provided a material economic benefit to the estate as a whole,  
2933 irrespective of whether the activities resulted in additional benefits to  
2934 covered claimants. The court shall approve such expenses unless it  
2935 finds the receiver abused his or her discretion in approving the  
2936 expenses. If the receiver determines that the assets of the estate will be  
2937 sufficient to pay all class 1 claims in full, class 2 claims shall be paid  
2938 currently, provided [that] the liquidator shall secure from each of the  
2939 associations receiving disbursements pursuant to this section an  
2940 agreement to return to the liquidator such disbursement, together with  
2941 investment income actually earned on such disbursements, as may be  
2942 required to pay class 1 claims. No bond shall be required of any such  
2943 association.

2944 Sec. 92. Subsection (a) of section 38a-944a of the general statutes is  
2945 repealed and the following is substituted in lieu thereof (*Effective*  
2946 *October 1, 2017*):

2947 (a) Notwithstanding any provision of sections 38a-903 to 38a-961,  
2948 inclusive, including any provision permitting the modification of  
2949 contracts, or other law of a state, no person shall be stayed or  
2950 prohibited from exercising: (1) A contractual right to terminate,  
2951 liquidate or close out any netting agreement or qualified financial  
2952 contract with an insurer because of: (A) The insolvency, financial  
2953 condition or default of the insurer at any time, provided [that] the right  
2954 is enforceable under applicable law other than sections 38a-903 to 38a-  
2955 961, inclusive, or (B) the commencement of a formal delinquency

2956 proceeding under sections 38a-903 to 38a-961, inclusive; [. (2) Any] (2)  
2957 any right under a pledge, security, collateral or guarantee agreement  
2958 or any other similar security arrangement or credit support document  
2959 relating to a netting agreement or qualified financial contract; [. (3)  
2960 Subject] or (3) subject to any provision of subsection (b) of section 38a-  
2961 932, any right to set off or net out any termination value, payment  
2962 amount, or other transfer obligation arising under or in connection  
2963 with a netting agreement or qualified financial contract where the  
2964 counterparty or its guarantor is organized under the laws of the  
2965 United States or a state or foreign jurisdiction approved by the  
2966 Securities Valuation Office of the National Association of Insurance  
2967 Commissioners as eligible for netting.

2968 Sec. 93. Subsection (b) of section 38a-985 of the general statutes is  
2969 repealed and the following is substituted in lieu thereof (*Effective*  
2970 *October 1, 2017*):

2971 (b) Upon receipt of a written request within ninety business days  
2972 from the date of the mailing of notice or other communication of an  
2973 adverse underwriting decision to an applicant, policyholder or  
2974 individual proposed for coverage, the insurance institution or agent  
2975 shall furnish such person [within] not later than twenty-one business  
2976 days [from] after the date of receipt of such written request: (1) The  
2977 specific reason for the adverse underwriting decision, in writing, if  
2978 such information was not initially furnished in writing pursuant to  
2979 subdivision (1) of subsection (a) of this section; (2) the specific items of  
2980 personal and privileged information that support those reasons,  
2981 [provided] except that: (A) The insurance institution or agent shall not  
2982 be required to furnish specific items of privileged information if it has  
2983 a reasonable suspicion, based upon specific information available for  
2984 review by the commissioner, that the applicant, policyholder or  
2985 individual proposed for coverage has engaged in criminal activity,  
2986 fraud, material misrepresentation or material nondisclosure, and (B)  
2987 specific items of medical-record information supplied by a medical-  
2988 care institution or medical professional shall be disclosed either  
2989 directly to the individual to whom the information relates or to a

2990 medical professional designated by the individual and licensed to  
2991 provide medical care with respect to the condition to which the  
2992 information relates; and (3) the names and addresses of the  
2993 institutional sources that supplied the specific items of information  
2994 pursuant to subdivision (2) of subsection (b) of this section, [provided]  
2995 except that the identity of any medical professional or medical-care  
2996 institution shall be disclosed either directly to the individual or to the  
2997 designated medical professional.

2998 Sec. 94. Subsection (b) of section 38a-995 of the general statutes is  
2999 repealed and the following is substituted in lieu thereof (*Effective*  
3000 *October 1, 2017*):

3001 (b) An insurance institution, agent or insurance-support  
3002 organization [which] that discloses information in violation of section  
3003 38a-988 shall be liable for damages sustained by the individual  
3004 concerning whom the information relates, [provided] except that no  
3005 individual shall be entitled to a monetary award [which] that exceeds  
3006 the actual damages sustained by [him] such individual as a result of a  
3007 violation of section 38a-988.

3008 Sec. 95. Subdivision (3) of subsection (e) of section 38a-1081 of the  
3009 general statutes is repealed and the following is substituted in lieu  
3010 thereof (*Effective October 1, 2017*):

3011 (3) Any employee of the exchange whose primary purpose is to  
3012 assist individuals or small employers in selecting health insurance  
3013 plans offered [on] through the exchange to purchase shall be licensed  
3014 as an insurance producer under chapter 701a not later than eighteen  
3015 months after such employee begins employment with the exchange.

3016 Sec. 96. Subsection (c) of section 53a-215 of the general statutes is  
3017 repealed and the following is substituted in lieu thereof (*Effective*  
3018 *October 1, 2017*):

3019 (c) For the purposes of this section, "insurance company" [means  
3020 "insurance company" as defined] has the same meaning as provided in

3021 section 38a-1.

3022 Sec. 97. Section 38a-507 of the general statutes is repealed and the  
3023 following is substituted in lieu thereof (*Effective October 1, 2017*):

3024 Each individual health insurance policy providing coverage of the  
3025 type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-  
3026 469, delivered, issued for delivery, renewed, amended or continued in  
3027 this state shall provide coverage for services rendered by a  
3028 chiropractor licensed under chapter 372 to the same extent coverage is  
3029 provided for services rendered by a physician, if such chiropractic  
3030 services (1) treat a condition covered under such policy, and (2) are  
3031 within those services a chiropractor is licensed to perform.

3032 Sec. 98. Subdivision (8) of subsection (a) of section 38a-88a of the  
3033 general statutes is repealed and the following is substituted in lieu  
3034 thereof (*Effective October 1, 2017*):

3035 (8) "Income year" means (A) with respect to corporations subject to  
3036 taxation under chapter 208, the income year as determined under said  
3037 chapter, (B) with respect to insurance companies, hospital service  
3038 corporations and medical [services] service corporations subject to  
3039 taxation under chapter 207, the income year as determined under said  
3040 chapter, and (C) with respect to taxpayers subject to taxation under  
3041 chapter 229, the taxable year determined under chapter 229;

3042 Sec. 99. Subdivision (7) of subsection (a) of section 38a-495a of the  
3043 general statutes is repealed and the following is substituted in lieu  
3044 thereof (*Effective October 1, 2017*):

3045 (7) "Medicare supplement policy" means (A) a group or individual  
3046 policy of accident and sickness insurance or (B) a subscriber contract of  
3047 hospital [and] service corporations, medical service corporations or  
3048 health care centers, other than a policy issued pursuant to a contract  
3049 under Section 1876 of the federal Social Security Act, [(42 USC Section  
3050 1395 et seq.)] 42 USC 1395 et seq., or (C) an issued policy under a  
3051 demonstration project specified in 42 USC [Section] 1395ss(g)(1),

3052 [which] that is advertised, marketed or designed primarily as a  
3053 supplement to reimbursements under Medicare for the hospital,  
3054 medical or surgical expenses of persons eligible for Medicare.

3055 Sec. 100. Subsection (a) of section 38a-495b of the general statutes is  
3056 repealed and the following is substituted in lieu thereof (*Effective*  
3057 *October 1, 2017*):

3058 (a) As used in sections 38a-473, as amended by this act, 38a-474, as  
3059 amended by this act, and 38a-481, subsection (l) of section 38a-495a,  
3060 sections 38a-495c and 38a-513 and this section, "Medicare" means the  
3061 Health Insurance for the Aged Act, Title XVIII of the Social Security  
3062 Amendments of 1965, as amended from time to time (Title I, Part I of  
3063 P.L. 89-97). For policies or certificates delivered or issued for delivery  
3064 to any resident of this state who is eligible for Medicare, prior to July  
3065 30, 1992, "Medicare supplement policy" means any individual or group  
3066 health insurance policy or certificate delivered or issued for delivery to  
3067 any resident of the state who is eligible for Medicare, except any long-  
3068 term care policy as defined in sections 38a-501, as amended by this act,  
3069 and 38a-528, as amended by this act. For policies or certificates  
3070 delivered or issued for delivery to any resident on or after July 30,  
3071 1992, "Medicare supplement policy" means (A) a group or individual  
3072 policy of accident and sickness insurance or (B) a subscriber contract of  
3073 hospital [and] service corporations, medical service corporations or  
3074 health care centers, other than a policy issued pursuant to a contract  
3075 under Section 1876 or Section 1833 of the federal Social Security Act,  
3076 [(42 USC Section 1395 et seq.)] 42 USC 1395 et seq., or (C) an issued  
3077 policy under a demonstration project authorized pursuant to  
3078 amendments to the federal Social Security Act, [which] that is  
3079 advertised, marketed or designed primarily as a supplement to  
3080 reimbursements under Medicare for the hospital, medical or surgical  
3081 expenses of persons eligible for Medicare.

3082 Sec. 101. Subsection (a) of section 38a-579 of the general statutes is  
3083 repealed and the following is substituted in lieu thereof (*Effective*  
3084 *October 1, 2017*):

3085 (a) The commissioner shall issue a certificate of authority if [he] the  
3086 commissioner is satisfied that the following conditions are met: (1) The  
3087 persons responsible for conducting the affairs of the dental plan  
3088 organization are competent and professionally capable of providing,  
3089 arranging for or administering the services offered by the plan; (2) the  
3090 dental plan organization constitutes an appropriate mechanism to  
3091 achieve an effective dental plan, as determined by the commissioner;  
3092 (3) the dental plan organization has demonstrated the potential to  
3093 provide dental services in a manner that will assure both availability  
3094 and accessibility of adequate personnel and facilities; (4) the dental  
3095 plan organization has arrangements for an ongoing quality of dental  
3096 care assurance program; (5) the dental plan organization has a  
3097 procedure to establish and maintain uniform systems of cost  
3098 accounting and reports and audits that meet the requirements of the  
3099 commissioner; (6) the dental plan organization is financially  
3100 responsible and may reasonably be expected to meet its obligations to  
3101 enrollees. In making this determination the commissioner shall  
3102 consider (A) the financial soundness of the dental plan's arrangements  
3103 for services and the schedule of charges used, (B) any arrangement  
3104 with an insurer, [or] a hospital [or] service corporation, a medical  
3105 service corporation or a dental service corporation for continuation of  
3106 coverage in the event of discontinuance of the plan on an indemnity  
3107 basis through a group vehicle to the end of the period for which  
3108 premiums were paid to the discontinued dental plan organization, and  
3109 (C) the sufficiency of an agreement with dentists for the provision of  
3110 dental services; (7) whether a general surplus is maintained as  
3111 required in section 38a-580; and (8) the condition or methods of  
3112 operation of the dental plan organization are not such as would render  
3113 its operations hazardous to its enrollees or the public.

3114 Sec. 102. Subsection (d) of section 38a-495a of the general statutes is  
3115 repealed and the following is substituted in lieu thereof (*Effective*  
3116 *October 1, 2017*):

3117 (d) Except as otherwise specifically provided in subdivision (4) of  
3118 subsection (l) of this section, the provisions of this section shall not

3119 apply to insurance policies or health care benefit plans [, including  
 3120 group conversion policies,] provided to Medicare eligible persons  
 3121 which policies are not marketed or held to be Medicare supplement  
 3122 policies or benefit plans.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2017</i>	5-259(e)
Sec. 2	<i>October 1, 2017</i>	12-211(c)
Sec. 3	<i>October 1, 2017</i>	19a-904b
Sec. 4	<i>October 1, 2017</i>	38a-14
Sec. 5	<i>October 1, 2017</i>	38a-48(b)
Sec. 6	<i>October 1, 2017</i>	38a-78(d)(2)
Sec. 7	<i>October 1, 2017</i>	38a-78(g)(2)
Sec. 8	<i>October 1, 2017</i>	38a-132(b)(1)
Sec. 9	<i>October 1, 2017</i>	38a-135(o)(3)(A)
Sec. 10	<i>October 1, 2017</i>	38a-156a(c)(2)
Sec. 11	<i>October 1, 2017</i>	38a-156j(c)(2)
Sec. 12	<i>October 1, 2017</i>	38a-194(a) and (b)
Sec. 13	<i>October 1, 2017</i>	38a-199(b) and (c)
Sec. 14	<i>October 1, 2017</i>	38a-214(b) and (c)
Sec. 15	<i>October 1, 2017</i>	38a-236
Sec. 16	<i>October 1, 2017</i>	38a-250(1)
Sec. 17	<i>October 1, 2017</i>	38a-250(5)
Sec. 18	<i>October 1, 2017</i>	38a-250(12)
Sec. 19	<i>October 1, 2017</i>	38a-262
Sec. 20	<i>October 1, 2017</i>	38a-263
Sec. 21	<i>October 1, 2017</i>	38a-264
Sec. 22	<i>October 1, 2017</i>	38a-308(b)
Sec. 23	<i>October 1, 2017</i>	38a-310
Sec. 24	<i>October 1, 2017</i>	38a-311
Sec. 25	<i>October 1, 2017</i>	38a-323b
Sec. 26	<i>October 1, 2017</i>	38a-341
Sec. 27	<i>October 1, 2017</i>	38a-343
Sec. 28	<i>October 1, 2017</i>	38a-343a
Sec. 29	<i>October 1, 2017</i>	38a-345
Sec. 30	<i>October 1, 2017</i>	38a-371(f)
Sec. 31	<i>October 1, 2017</i>	38a-433(a)
Sec. 32	<i>October 1, 2017</i>	38a-439(b)



Sec. 33	October 1, 2017	38a-439(e)
Sec. 34	October 1, 2017	38a-440(a)
Sec. 35	October 1, 2017	38a-465p(a)
Sec. 36	October 1, 2017	38a-472(a)
Sec. 37	October 1, 2017	38a-472g(a)
Sec. 38	October 1, 2017	38a-473
Sec. 39	October 1, 2017	38a-474
Sec. 40	October 1, 2017	38a-475
Sec. 41	October 1, 2017	38a-476(a)(1)
Sec. 42	October 1, 2017	38a-476a
Sec. 43	October 1, 2017	38a-477d(a)(2)
Sec. 44	October 1, 2017	38a-477d(c)
Sec. 45	October 1, 2017	38a-477e(a)
Sec. 46	October 1, 2017	38a-478g(b)(8)
Sec. 47	October 1, 2017	38a-479qq(a)(8)
Sec. 48	October 1, 2017	38a-482c(a)
Sec. 49	October 1, 2017	38a-483a
Sec. 50	October 1, 2017	38a-489(a)
Sec. 51	October 1, 2017	38a-492d
Sec. 52	October 1, 2017	38a-492e(a)
Sec. 53	October 1, 2017	38a-492m
Sec. 54	October 1, 2017	38a-493
Sec. 55	October 1, 2017	38a-499a(a)
Sec. 56	October 1, 2017	38a-501(a) and (b)
Sec. 57	October 1, 2017	38a-503a(a)
Sec. 58	October 1, 2017	38a-505(2) to (5)
Sec. 59	October 1, 2017	38a-512c(a)
Sec. 60	October 1, 2017	38a-515(a)
Sec. 61	October 1, 2017	38a-518d
Sec. 62	October 1, 2017	38a-518e(a)
Sec. 63	October 1, 2017	38a-518l
Sec. 64	October 1, 2017	38a-520
Sec. 65	October 1, 2017	38a-522(b)
Sec. 66	October 1, 2017	38a-526a(a)
Sec. 67	October 1, 2017	38a-528(a) and (b)
Sec. 68	October 1, 2017	38a-530a(a)
Sec. 69	October 1, 2017	38a-530c(b)
Sec. 70	October 1, 2017	38a-530c(e)
Sec. 71	October 1, 2017	38a-532
Sec. 72	October 1, 2017	38a-564(7)
Sec. 73	October 1, 2017	38a-569(d)(2)

Sec. 74	October 1, 2017	38a-582
Sec. 75	October 1, 2017	38a-672(b)
Sec. 76	October 1, 2017	38a-673(c)
Sec. 77	October 1, 2017	38a-675(b)
Sec. 78	October 1, 2017	38a-686(b)(3)
Sec. 79	October 1, 2017	38a-688
Sec. 80	October 1, 2017	38a-702a
Sec. 81	October 1, 2017	38a-712(c)
Sec. 82	October 1, 2017	38a-716(a)
Sec. 83	October 1, 2017	38a-720j(f)
Sec. 84	October 1, 2017	38a-720l(a)
Sec. 85	October 1, 2017	38a-775(a)
Sec. 86	October 1, 2017	38a-790(d)(1)
Sec. 87	October 1, 2017	38a-838(11)
Sec. 88	October 1, 2017	38a-862(16)
Sec. 89	October 1, 2017	38a-939(c)
Sec. 90	October 1, 2017	38a-941(e)
Sec. 91	October 1, 2017	38a-944(a)(2)
Sec. 92	October 1, 2017	38a-944a(a)
Sec. 93	October 1, 2017	38a-985(b)
Sec. 94	October 1, 2017	38a-995(b)
Sec. 95	October 1, 2017	38a-1081(e)(3)
Sec. 96	October 1, 2017	53a-215(c)
Sec. 97	October 1, 2017	38a-507
Sec. 98	October 1, 2017	38a-88a(a)(8)
Sec. 99	October 1, 2017	38a-495a(a)(7)
Sec. 100	October 1, 2017	38a-495b(a)
Sec. 101	October 1, 2017	38a-579(a)
Sec. 102	October 1, 2017	38a-495a(d)

**Statement of Legislative Commissioners:**

In Section 100, "as amended by this act," was deleted for consistency with drafting conventions.

**INS**      *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

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***OFA Fiscal Note******State Impact:*** None***Municipal Impact:*** None***Explanation***

The bill makes technical and clarifying changes to insurance statutes and does not result in a fiscal impact to the state or municipalities.

***The Out Years******State Impact:*** None***Municipal Impact:*** None

**OLR Bill Analysis****sSB 946*****AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL AND OTHER CHANGES TO THE INSURANCE AND RELATED STATUTES.*****SUMMARY**

This bill makes several minor, technical, and conforming changes to the insurance statutes. Among other things, it:

1. specifies that health carriers must update and maintain provider directories in accordance with existing, more detailed provisions enacted in PA 16-205 (§ 3);
2. removes obsolete references to health insurance conversion provisions (i.e., provisions allowing conversion of job-based insurance to an individual policy if eligibility for the job-based insurance is lost) (§§ 12 & 102);
3. specifically adds credit and travel insurance to limited lines insurance, which under existing law also includes any other line of insurance that the commissioner finds necessary to comply with certain nonresident licensing laws (§ 80);
4. specifies the type of individual health insurance policies that must cover chiropractic services (§ 97); and
5. specifies that certain examination provisions that currently apply to insurers also apply to (a) health care centers (i.e., HMOs), (b) corporations or associations collecting an insurer's underwriting data, and (c) any corporation engaged in certain insurance and securities transactions (§ 4).

EFFECTIVE DATE: October 1, 2017.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea     21     Nay   0     (03/15/2017)